Paediatrics & Child Health, 2019, 1–4
doi: 10.1093/pch/pxz053
Case Report

Case Report

A case report and literature review: Factitious disorder imposed on another and malingering by proxy

Ilana C. Walters BA&Sc MSc, Rachel MacIntosh MD, Kim D. Blake MD FRCP

Dalhousie University, Faculty of Medicine, IWK Health Centre, Halifax, Nova Scotia

Correspondence: Kim Blake, Dalhousie University, Faculty of Medicine, IWK Health Centre, 5850/5980 University Avenue, Halifax, B3K 6R8, Nova Scotia. Telephone 902-470-6499, fax 902-470-6913, e-mail kblake@dal.ca

Abstract

Factitious disorder imposed on another (FDIA) and malingering by proxy (MAL-BP) are two forms of underreported child maltreatment that should remain on physicians' differential. This case of a 2-year-old boy, which spans 6 years, reveals the complexity in and difficulties with diagnosis. Key features include the patient's mother using advanced medical jargon to report multiple disconnected concerns and visits to numerous providers. As a result, the patient underwent many investigations which often revealed normal findings. FDIA was suspected by the paediatrician, especially following corroboration with the child's day care and past primary health care provider. This case demonstrates the possible overlap in diagnoses, which are characterized by a lack of consistent presentation and deceitful caregivers, often complicated by true underlying illness. The authors use clinical experience and limited existing literature to empower paediatricians to confidently diagnose and report FDIA and MAL-BP to limit future harm to children.

Keywords: *Child abuse; Factitious disorders; Malingering; Munchausen syndrome by proxy*

Factitious disorder imposed on another (FDIA), and malingering by proxy (MAL-BP) are two forms of child maltreatment that are often unrecognized and underreported (1–3). FDIA has previously been called Munchausen syndrome by proxy, caregiver fabricated illness, and medical child abuse (1,4,5). This evolution reflects the current view that FDIA is a psychiatric diagnosis given to the perpetrating caregiver (6). These disorders must remain on physicians' differential as both can result in significant harm to the child and a burden on society (3).

FDIA is the falsification of signs/symptoms or induction of injury or disease in a proxy, associated with identified deception and without external reward (6). The signs/symptoms are induced by the caregiver and can result in the child receiving unnecessary and potentially harmful care (1). Long-term implications of FDIA for the child include behavioural, emotional, or intellectual challenges (7,8). Mortality is estimated in 6 to 30% of the cases (5,8,9). FDIA should be suspected if the caregiver fabricates a history of illness, exaggerates a real disease, or underreports signs/symptoms. The paediatrician should recognize common behaviour patterns, such as seeking alternate medical opinions, resisting reassurance that the child is healthy or reporting unexplained signs/symptoms (1,2,10).

MAL-BP is maltreatment caused by a caregiver intentionally inducing or reporting false or exaggerated signs/symptoms in a proxy, motivated by external incentives (3,11). The distinguishing factor between FDIA and MAL-BP is the presence of external reward which is exclusionary of FDIA and diagnostic of MAL-BP. Critical to the paediatrician's role in such cases is to identify and reduce harm to the child, rather than formalizing caregiver motive and diagnosis (1,2,12).

CASE DESCRIPTION

A 2-year-old male presented to the local children's emergency department for a fever of unknown origin. He was accompanied by his mother who recently relocated. The fevers, reported by his mother, recurred biweekly over the previous 6 months and

Received: November 27, 2018; Accepted: March 7, 2019

Table 1. Chronology of a male presenting at age 2 with a caregiver with factitious disorder imposed on another (FDIA) and malingering by proxy (MAL-BP) over a 6-year period

Chronology	*Reasons for contact*	*Consults, investigations, interventions*	*Findings, diagnosis*
2008–2014	'Bottle rot', pain from back teeth, chipped front tooth	Class I enamel fracture, later underwent full dental rehabilitation under general anaesthetic	Dental x-rays, later diagnosed with severe early childhood caries
2008	Fevers, bruising, large lymph nodes, ear infections, head banging, requesting tonsillectomy. Mother later reported *leukemia	Blood work, CT scan of head and abdomen, chest x- ray, ENT consult	Normal results in keeping with viral infection
2009	Requesting urology consult for undescended testis	Urology consult	Normally descended testes bilaterally
2009	Cracked right thumbnail	Dermatology consult, plastic surgery consult Thumbnail paring down, full nail removal under general anaesthetic	Subungual tissue growth of right thumb nail, onycholysis, hyperkeratosis, onychomycosis
2009	Possible seizure activity, *concussion, penis lesion, undescended testis	EEG, neurology consult	Non-specific lesion on penis, Normal EEG
2010- 2013	Concerns about hearing, loud speaking, sore throat, recurrent ear infections, request for tonsillectomy	ENT consult, hearing and speech consult Audiogram, lateral airway test Adenoidectomy, myringotomy	Middle ear effusion Moderately sized adenoids
2010	Recurrent throat infections, request for tonsillectomy, speech concerns	Speech therapy consult	Slightly enlarged tonsils
2011	Undescended testis, head banging, behavioral issues	None	Small indent on head, no evidence of cryptorchidism
2011	Skin sensitivity, allergy	Allergy consult Epicutaneous tests	No demonstrated allergies
2011	ADHD, fine motor control concerns	ADHD checklist for diagnosis, occupational therapy consult	ADHD, learning disability
2013	*Autism, *Asperger's, *pervasive developmental disorder	Neurology consult, developmental paediatrics consult, health psychology consult	Childhood tic disorder, learning disability, ADHD. Multiple stimulant trials with unfavourable side effects.
2013	Small bump on left eye	Ophthalmology consult	Small dermoid cyst, no further treatment
2013	Left knee pain	Seen in emergency, orthopedics consult x-ray, bone scan of left leg	Antalgic gait x-ray revealed mild changes, normal bone scan

Table 1. Continued

Chronology	*Reasons for contact*	*Consults, investigations, interventions*	*Findings, diagnosis*
2014	Right knee pain, *Marfan syndrome	Orthopedic consult Repeat x-ray, bone scan Rheumatology consult, blood work	Normal findings
2014	Leg pain, requesting MRI, suggesting *Legg-Calvé-Perthes	None	Normal exam

This table does not document all visits with health care providers and amalgamates series of specialist consults that occurred over many months. Our patient's mother was also calling the paediatrician's office weekly to request clinic visits and specialist consultations throughout this period.

*Indicates typical medical terminology used by our patient's mother.

ADHD Attention-deficit hyperactivity disorder; CT Computerized tomography; EEG Electroencephalogram; ENT Otolaryngology.

persisted for a few days each time. There were no associated signs or symptoms, except a recent maculopapular rash. During a paediatric consult, the patient's mother presented distressed, using advanced medical jargon to ask a multitude of questions unrelated to the initial complaint. The patient's mother expressed concern of easy bruising, cervical lymphadenopathy, head banging, and requested a tonsillectomy. The patient was mildly febrile with a viral presentation and displayed moderate cervical lymphadenopathy. Blood work and x-rays were normal.

The paediatrician became the main health care provider and initiated contact with his previous family physician and day care. This revealed numerous physician contacts throughout the region, including multiple visits to emergency departments and walk-in clinics. The day care reported that our patient's mother stated that he was absent from day care due to a recent relocation and admission to the children's hospital for leukemia. There was no evidence of this diagnosis in any medical records.

Over the following 6 years, our patient had multiple appointments with various specialists which resulted in numerous investigations that mainly yielded negative results. Our patient's mother was noted to be verbally aggressive to office staff and regularly reported inconsistent histories and fabricated diagnoses to physicians and schoolteachers. Reports were made to child protection services by the paediatrician on two occasions for concerns of FDIA. Twelve specialists and seven allied health professionals were consulted; this included emergency, general surgery, urology, otolaryngology, neurology, developmental paediatrics, plastic surgery, dermatology, allergy, orthopedics, ophthalmology, rheumatology, dentistry, health psychology, physiotherapy, occupational therapy, speech therapy, audiology, and social work. Consistently throughout the 6-year period, our patient's mother was in weekly contact with the paediatrician's office to request additional clinic visits and consultations. Table 1 summarizes our patient's consultations, investigations, and diagnoses. Recorded prescriptions for our patient include methylphenidate, dextroamphetamine, ratio-morphine, and atomoxetine.

After 6 years of ongoing medical visits, investigations, and frequent absenteeism from school, our patient was diagnosed with severe early childhood caries, middle ear effusion, childhood tic disorder, attention-deficit hyperactivity disorder (ADHD), and a learning disability, while ruling out a multitude of other illnesses. Following this, our patient's mother was incarcerated for drug trafficking prescription medications including hydromorphone, dextroamphetamine, and clonazepam.

CONCLUSION

This case highlights the importance of keeping FDIA and MAL-BP on the paediatrician's differential diagnosis. The diagnosis is always challenging and must be balanced with limiting harm to the child. Recognizing the coexistence of FDIA and MAL-BP in this case is important only for identifying the means of maltreatment.

FDIA is underreported by physicians because of elusive evidence (12), deceit by the caregiver, and misleading but true medical illness in up to 55% of the patients (9). Other barriers include physicians' hesitance to miss a condition and fear of losing access to the child for care. Physicians are in a critical position to prevent future maltreatment because harm to the child is often iatrogenic (12). If the child appears well and not at risk of serious injury, physicians should follow closely and limit extensive investigations to reduce harm (10).

A common strategy to diagnose FDIA and MAL-BP is converging multiple sources to corroborate or discredit reported signs/symptoms or illness (10,11). In this case, contact with day care workers was most beneficial as they had frequent contact with our patient and his mother and could validate the physician's suspicion. It is also effective to have one primary therapeutic relationship (10). In this case, the paediatrician was able to streamline the child's care by centralizing reports from

other providers while acting as a gatekeeper to the system. It is paramount that the child continues to receive rightful diagnoses and treatment. In this case, the diagnosis of ADHD was re-evaluated and confirmed by a third party in an unbiased setting.

These strategies empower paediatricians to report and involve child protective services early in suspected cases. The preferred approach is to report suspected child maltreatment based on the harmful implications of the parent's behaviour on the child, rather than the diagnosis itself (10).

Disclaimer: The reports included in this case are limited by constraints of medical records, in that physician visits beyond the Halifax regional municipality (HRM) are not accessible and thus are not included in this case.

Informed consent: Consent was obtained from a parent for publication of this case.

Funding Information: There are no funders to report for this submission.

Potential Conflicts of Interest: All authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References

1. Flaherty EG, Macmillan HL; Committee on Child Abuse and Neglect. Caregiver-fabricated illness in a child: A manifestation of child maltreatment. Pediatrics 2013;132(3):590–7.
2. Stirling J Jr; American Academy of Pediatrics Committee on Child Abuse and Neglect. Beyond Munchausen syndrome by proxy: Identification and treatment of child abuse in a medical setting. Pediatrics 2007;119(5):1026–30.
3. Amlani A, Grewal GS, Feldman MD. Malingering by proxy: A literature review and current perspectives. J Forensic Sci 2016;61 (Suppl 1):S171–6.
4. Tatu L, Aybek S, Bogousslavsky J. Munchausen syndrome and the wide spectrum of factitious disorders. Front Neurol Neurosci 2018;42:81–6.
5. Doughty K, Rood C, Patel A, Thackeray JD, Brink FW. Neurological manifestations of medical child abuse. Pediatr Neurol 2016;54:22–8.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th edn. Arlington, VA: American Psychiatric Association, 2013.
7. Boyd AS, Ritchie C, Likhari S. Munchausen syndrome and Munchausen syndrome by proxy in dermatology. J Am Acad Dermatol 2014;71(2):376–81.
8. Sheridan MS. The deceit continues: An updated literature review of Munchausen Syndrome by Proxy. Child Abuse & Neglect 2003;27(4):431–51.
9. Shaw RJ, Dayal S, Hartman JK, DeMaso DR. Factitious disorder by proxy: Pediatric condition falsification. Harv Rev Psychiatry 2008;16(4):215–24.
10. Glaser D, Davis P. For debate: Forty years of fabricated or induced illness (FII): Where next for paediatricians? Paper 2: Management of perplexing presentations including FII. Arch Dis Child 2019;104(1):7–11. doi:10.1136/archdischild-2016–311326
11. Bass C, Halligan P. Factitious disorders and malingering: Challenges for clinical assessment and management. Lancet 2014;383(9926):1422–32.
12. Davis P, Murtagh U, Glaser D. 40 years of fabricated or induced illness (FII): Where next for paediatricians? Paper 1: Epidemiology and definition of FII. Arch Dis Child 2019;104(2):110–4.