

# Factitious Fever

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Factitious fever is one of the causes of fever of unknown origin. It is usually an atypical presentation of a common disease (Wolff et al., 1975; Adison et al., 1978; Keefer and Leard, 1955; Petersdorf and Beeson, 1961). Asher (1951) described Munchausen's syndrome, which includes several examples of factitious fever. It represents a large group of false illnesses varying from malingering to personality disorders. Patients tend to appear sick and seek medical advice by distorting their histories and physical findings and often laboratory tests. They tend to shift from hospital to hospital once the factitious nature of their illness is uncovered (Spiro, 1968) and often leave the hospital against medical advice. Chronic factitious illness is usually superimposed on a severe personality disorder varying from psychosis to neurosis (Spiro, 1968; Cramer et al., 1971; Barney, 1978). Conversion reactions like hysterical blindness, seizures, paralysis and anorexia nervosa can also occur, but conversion disorders are more in passive aggressive personalities (Kernberg, 1970).

Factitious Fever is more common amongst medical and paramedical staff e.g. nurses, pharmacists, bacteriologist, laboratory technicians and medical students, because of their familiarity with the hospital, easy access to thermometers and drugs and because of the prompt attention given to them by their fellow members (Sonenthal, 1944).

Various methods of producing fraudulent fever are: (a) thermometer manipulation e.g. applying external heat to the thermometer, changing the thermometer with that of a high temperature recording or dipping it in hot solution or wrong reporting of the fever by parents (Sjoberg, 1951; Clarke and Melnick, 1958; Steinbeck, 1961; Daily et al., 1963; Thompson et al., 1964; Trew and Anderson, 1970; Gershwin et al., 1971; Robert et al., 1979; Herzberg and Wolf, 1972; McClung, 1972). True factitious fever does not occur in children younger than 10 years of age because of their inability to manipulate with thermometers. Thermometer manipulation can be suspected when the high temperature does not correlate with the physical findings, absence of tachycardia, skin warmth and when there is marked difference between the oral and rectal temperatures or there is lack of diurnal variation.

(b) Fever can also be produced by self inoculation of bacterial cultures, toxoids and milk. Cases of recurrent abscesses, cellulitis and self inflicted skin lesions due to self injection of tetanus toxoid, coliform bacilli, human and animal faecal organisms, tubercle bacilli *Pseudomonas aeruginosa* and *Streptococcus viridans* have been reported (Laws, 1951; Trew and Anderson, 1970; Sullivan and Trosow, 1949; Raff et al., 1975; Jones et al., 1949; Chien and Wiggins, 1954; Robert et al., 1979; Kuvin, 1962; Keefer and Leard, 1955; Steinman et al., 1975; Shepard and Sawyers, 1969; Ackerman et al., 1966). Polymicrobial bacteremia with *E. Coli*, group D streptococci and *Proteus mirabilis* can also occur (Robert et al., 1979; Herman and Washington, 1970), but fortunately the normal host clears off such infections quite easily and without any residual changes.

(c) Drugs can also produce fever. The drugs commonly associated and reported to cause fever are antibiotics (Penicillins and sulphonamides), barbiturates, phenytoin, procainamide, quinidine, atropine, propylthiouracil, chlorpromazine, diphenhydantoin and phenolphthalein (Petersdorf and Beeson, 1961; Effersoe, 1968; Robert et al., 1979; Jacoby and Swartz, 1973; Clutt and Johnson, 1964). Salicylates and iodides cause fever in children and high doses of thyroxine also produce pyrexia (McClung, 1972; Wolf and Jacobs, 1947).

Factitious Fever might complicate an existing or resolving disease (Hale and Evseichick, 1943). It has also been reported in association with other systemic illness, e.g. dental infection (Sjoberg, 1951), diarrhoea (French et al., 1956), C.N.S. infection (Clark and Melnick, 1958; York, 1960), genitourinary bleeding (Steinbeck, 1961) and G.I. bleeding (Seiffers and Welner, 1969), anaemia (Daily et al., 1963),

neurological disease (Michaels et al., 1964), Pulmonary embolism (Trew and Anderson, 1970) and subcutaneous emphysema (Gershwin et al., 1971).

Two subgroups of patients with factitious disease are seen. First group comprises of younger patients who manipulated their thermometers after a genuine episode of fever; just to gain attention. Their psychopathology varies. The second group is of older subjects with serious underlying psychiatric illness (borderline syndrome). They create illness by self infection. The term borderline syndrome is applied to a heterogeneous group of patients whose personality varies between neurosis and psychosis (Knight, 1953; Grinker et al., 1968; Cernberg, 1967; Gunerson and Singer, 1975; Stone, 1977; Perry and Klerman, 1978). Borderline cases have defects in their self concepts, reality testing, and impulse control. They are superficially social but have feelings of hidden anger, hostility and self destruction.

The physician must not neglect coexisting medical illness while treating factitious fever or self induced infection. Life threatening complications, e.g. bacterial endocarditis, or septic pulmonary emboli can often occur in self induced infections. Bacteremia should be treated spontaneously. Early psychiatric consultation should be a part of the investigation for any patient with prolonged illness with or without psychiatric signs and symptoms.

Ideally the patient after seeing the psychiatrist should soon be seen by a therapist because of the considerable anger and rage against the physician and psychiatrist. Psychiatric hospitalization should be considered in those with suicidal tendencies. Patients with border line personality disorder are capable of producing conflicts amongst the ward staff, physicians and those all around them, so great care must be taken in keeping good relationship between the team. Limits must be set on the patient's unrealistic expectations and self destructive behaviour after disappointment. Limits must be set out by taking into account patient's real needs and his primitive defence mechanisms.

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