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Case Report

Behavioral Health Issues Presenting as Complex Medical Issues

Hannah E Maxfield*

Department of Family Medicine, University of Kansas, USA

***Corresponding author**
Hannah E Maxfield, University of Kansas Department of Family Medicine, Kansas City, USA. Tel: 9135881908

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DEAR EDITOR

Primary care physicians see a wide variety of complex patients, new patients can be especially challenging since we can see both new patients with undifferentiated and undiagnosed medical problems to new patients with complex histories of previously diagnosed problems. Physicians should be able to confirm these diagnoses through their own research and review of previous medical records and should also consider concomitant psychiatric disorders that patients may not be as eager to share. It is most important to realize that building trust with the patient should their primary goal in order to establish an effective therapeutic relationship and be able to provide the best possible care.

CASE STUDY

28 yrs female presented to establish care. She was previously being seen in another large academic health system but had a change in insurance coverage. She reports an extensive medical history that includes gastroparesis, celiac disease, colorectal cancer, epilepsy, displacement of disc between L4/L5, spinal cord stimulator in place with dysfunction, LGSIL, migraine without aura, SLE with organ system involvement, atrial septal defect, patent foramen ovale, secondary adrenal insufficiency, Ehlers Danlos syndrome and mast cell activation syndrome. Her ROS was positive for the following: leg swelling, abdominal pain, constipation, nausea, urinary incontinence, gait problem, myalgias, color change, seizures, bruises/bleeds easily and dysphoric mood.

Physical exam was notable for abdominal exam. Abdomen was soft with active bowel sounds, no distention. There was diffuse tenderness. Her mood was anxious and withdrawn [1].

DEFINITION/SCOPE OF PROBLEM

Given the complexity of her medical history, previous medical records were requested. I was most interested in when and how each of these diagnoses had been made, as well as any previous treatments. While awaiting those, I reviewed each of these diagnoses, their typical presentation, diagnostic testing and treatment. I started with those that I had the most knowledge of the patient described several different gastrointestinal disorders including celiac disease, colorectal cancer and gastroparesis. These were the diagnoses I was most familiar with and I anticipating receiving colonoscopy results with possible biopsies as well as a gastric emptying study. There were a few diagnoses that I had a basic understanding of but still wanted to review. I was confident with the diagnosis of epilepsy is defined as 2 unprovoked seizures at least 24 hours apart, with definitive diagnosis being made through EEG. I reviewed postural orthostatic tachycardia syndrome, which is typically diagnosed through a tilt table testing. Systemic lupus erythematosus is an autoimmune condition which can affect many organ systems and initial diagnosis begins with lab testing. This is also true for secondary adrenal insufficiency which often manifests with vague symptoms such as weakness, fatigue, GI symptoms and hypoglycemia. It is diagnosed with an AM cortisol level and ACTH stimulation test. Treatment is based on the underlying cause, which can include chronic opioid use. Lastly, there were those diagnoses that I had a vague recollection of, either from previous USMLE testing or an episode of House, but which required a deeper dive to understand presenting symptoms, diagnostic testing and management options. These included Shy-Drager syndrome, Ehlers Danlos syndrome and MAST cell activation syndrome. Shy-Drager syndrome, which is now called Multiple System Atrophy (MSA) is a rare neurogenerative disorder. that typically develops in the 50s-60s. It is progressive, with most patients living only 7-10 years after diagnosis. Ehlers-Danlos Syndrome is characterized by joint hypermobility, multiple joint dislocations, translucent skin, poor wound healing, easy

bruising, unusual scars. Diagnosis is made through the use of major criteria and minor criteria. Major criteria are Skin hyperextensibility and atrophic scarring plus Generalized Joint Hypermobility (GJH) [2]. There are nine minor criteria. Minimal clinical standards suggesting cEDS are the first major criterion plus either the second major criterion or at least three minor criteria. A final diagnosis requires confirmation by molecular testing. More than 90% of those with cEDS have a heterozygous mutation in one of the genes encoding type V collagen (COL5A1 and COL5A2). Rarely, specific mutations in the genes encoding type I collagen can be associated with the characteristics of cEDS. Classical EDS is inherited in the autosomal dominant pattern MAST cell activation syndrome causes episodes that can include the following: Abdominal pain, Cramping, Diarrhea, Flushing, Itching, Wheezing, Coughing, Lightheadedness, Rapid pulse and Low blood pressure. It is also diagnosed through the use of major and minor criteria. Major criteria are the symptoms listed above that can be associated with pathologically elevated MAST cells. Minor criteria include increased MAST cells in marrow or other organs, abnormal spindle-shaped morphology in >25% of MAST cells in marrow sample, abnormal MAST cell expression of CD2/CD25, detection of genetic changes in mast cells which has caused increased activity, above-normal level of mast cells mediators (tryptase/heparin/chromogranin A in blood, histamine in urine) and reduced symptoms with antihistamines/cromolyn. Outside records arrived. After review, I was disappointed to find that they were unable to confirm many of these diagnoses, in fact, in several cases the patient had had appropriate testing that was normal. This included a normal gastric emptying test, a normal EEG, a normal tilt table test and a normal tryp tase. Many of the more uncommon diagnoses seemed to have Unable to find documentation of a previous colonoscopy with biopsies to confirm either celiac disease or colorectal cancer [3,4].

DIFFERENTIAL DX

Ultimately, I had to admit to myself that while it is possible for a single patient to carry all of these diagnoses, it is highly unlikely. This led me to consider diagnoses of factitious disorder, somatiform disorder or malingering. These diagnoses are sometimes used interchangeably but have distinct differences [5] (Table 1).

HOW TO MAKE THE DIAGNOSIS

The first thing to consider is whether the patient is intentionally creating or exaggerating symptoms. This occurs in both factitious disorder and malingering, but not in somatiform disorders. Next, consider what possible motivation the patient may have. Patients with factitious disorder have embraced the sick role as an essential part of their identity, while those who are malingering anticipate some kind of secondary gain such as avoiding tasks or obtaining benefits only provided to those with a particular diagnosis.

Table 1: Diagnoses of factitious disorder, somatiform disorder or malingering

	Intentional	Motivation	Symptoms	
Factitious disorder	Yes	Internal	Psychiatric	Have adopted the sick role, often as a way to get attention
Malingering	Yes	External	Not a mental illness, but can be associated with antisocial or histrionic personality disorders	Some secondary gain from playing the sick role
Somatiform disorder	No	Internal	Physical symptoms	Expression of psychological stress through physical symptoms

ANXIETY/DEPRESSION

Personality disorders (cluster B)

These diagnoses are primarily diagnoses of exclusion, which makes it extremely difficult to diagnose conclusively. When considering factitious disorder, practitioners may notice faking or exaggeration of symptoms, symptoms that only occur while being observed, willingness (and even eagerness) to have diagnostic tests or other procedures, long medical records of multiple admissions to different hospitals, reluctance by the patient to allow interaction of doctors with family members [6].

Based on this information, I diagnosed my patient with factitious disorder.

TREATMENT

The best treatment is medication with antidepressants/anxiolytics as well as cognitive behavioral therapy. This is rarely effective since patients remain convinced that they carry these diagnoses but just have not yet had the appropriate testing to confirm.

It can be difficult to avoid ordering unnecessary testing or treatments based on the patients perception of the continuing symptoms. It helps to keep the Hippocratic oath at the forefront of your mind – first, do no harm. Many of of diagnostic tests, and certainly our treatments come with their own risks [7,8].

COORDINATION OF CARE ISSUES

It is important that these patients have a care team that communicates, especially when it comes to new symptoms and additional diagnostic testing.

RESOLUTION OF CASE

When patient returned to clinic for her next appointment, I attempted to engage her in a discussion of the medical records I had received. As above, I discussed the diagnostic testing and treatments for each of her diagnoses, highlighting the fact that her medical records do not show documentation to confirm these. Unsurprisingly, patient became defensive and accused provider of "not believing her" but could not provide any supporting information. She has not returned to the clinic since that time.

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