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When Bloody Vomit Hides a Deeper Issue: A Case Series of Factitious Disorders with Hematemesis in Children

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Abstract

Factitious disorder presenting as hematemesis (FDH) is a rare condition in the pediatric population. Diagnosis and management in such cases are complex and often delayed due to unnecessary investigations leading to a waste of useful resources. We present a case series of eleven children with bloody vomitus/vomitus simulating blood. There is a pattern of recurrent medical visits, hospitalizations, and invasive procedures without a medical cause. FDH should be considered as one of the differential diagnoses of hematemesis in children with an unknown cause. A detailed history taking is the key to diagnosis. Early recognition and a multidisciplinary approach are essential to ensure appropriate management and prevent unnecessary medical interventions.

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Introduction

Factitious disorder (FD) is a rare disorder in children with a prevalence of about 0.03 to 0.7% among children aged 6 to 18 years of age.[1] Factitious disorder presenting as hematemesis (FDH) is a still rarer condition in children, with only a few cases reported in the literature.[2] In FDH, the patient brings out bloody vomitus/vomitus simulating blood to assume a sick role and gain medical attention with no secondary gains. There is a pattern of recurrent medical visits, hospitalizations, and invasive procedures without a medical cause. Thus, it is extremely difficult to diagnose and treat FDH.

Case Series

We present a case series of eleven children with chronic FDH (The study was conducted in a referral Medical college, and the cases were enrolled over a period of five years (January 2020 – January 2025), (Table 1). These children pre-

Table 1: Detailed clinical features of the study cases

S.no	*Case,age (yrs), Gender#*	*Presentation*	*Single parent*	*Substance used to simulate hematemesis*
1.	Y,8, F	Recurrent vomiting, initially large volume dark reddish vomitus, later blue, green, pink coloured	yes	Tailor's chalk
2.	S,12, M	Recurrent vomiting, dark red, large volume vomitus, seen during the day time.	yes	Mixture of guava and pomegranate juice
3.	A,11, M	Recurrent vomiting with dark red, large volume vomitus, seen by mother on returning from work.	No, mother is primary care giver	Mixture of carrot and pomegranate juice
4.	S,13, F	Episodic vomiting, only 4-5 days/ month, with dark red, small volume vomitus, occurring only in bathroom.	No	Menstrual blood
5.	K,16, M	Recurrent vomiting with dark reddish-purple, small volume watery vomitus, seen during morning hours immediately after getting up from bed.	No	Beetroot (The child used to hide beet roots under his pillow during the night and used to chew it in the early morning hours).
6.	S,17, F	Recurrent vomiting with very small volume bloody vomitus, during the day hours.	No	Child sucked blood from self-inflicted wounds to simulate hematemesis
7.	N,17, F	Recurrent vomiting with red, small volume watery vomitus.	No	Red coloured cough syrup (Syrup Chericof)
8.	U,13, F	Recurrent vomiting with bright red, small volume thick vomitus, during day hours.	No	Tomato ketchup
9.	S,10, M	Recurrent vomiting with very small volume bloody vomitus, during day hours.	Yes	Child sucked blood from carious tooth and swallow it and then induced vomiting by putting fingers in his throat.
10.	P,15, F	Recurrent vomiting with very small volume bloody vomitus, during daytime hours.	Yes	Blood from epistaxis induced by nose pricking and swallowing this blood to be later brought out as hematemesis.
11.	D, 14, F	Recurrent vomiting with very small volume bloody vomitus and blood in tears	No	Blood is extracted by chewing the oral mucosa and swallowing this blood, to be brought out as hematemesis and also used to colour tears red.

@RTA - road traffic accident,
Gender – F- female, M- Male

Stress trigger	*Duration (months)*	*Co-morbid depression*	*Follow-up*
Single working mother, school bully	2	No	Improved
Single working mother, child felt lonely	12	No	Improved
Father was a drug addict, emotional neglect	1	yes	Improved
Conflict between religious beliefs and personal aspiration. She was from a conservative Muslim family and wanted to go out like other girls	24	No	Improved
Mother was diagnosed with breast cancer and was undergoing chemotherapy and had lost all her hair, causing distressed to child. Also, parents were shifting him to a boarding school.	2–3 weeks	Yes	Improved
Child had boyfriend and mother objected to it.	1	No	Improved
Post traumatic stress disorder after RTA@ and parental neglect. She lived in a large joint family and when she was undergoing treatment, her mother stayed at home to cook food for family and father was at work, she was taken care of by her grandparents. During that time, she felt parental neglect and insensitiveness to her stress.	2	No	Improved
After her grandmother's death the child felt very lonely and had got into a relationship with a boy, who was about ten years older than her. Her mother objected to it, changed her school and residence, following she started simulating her grandmother's symptoms, who had deid of gastric cancer.	4	Yes	Improved
Father had committed suicide due to marital conflict and he felt emotional neglect	2	No	Recurrence of symptoms
Father's early death, school bully	1	No	Improved
The child was studying at a school far away from the parental house, staying with the uncle and aunt	9	No	Recurrence of symptoms

sented at different times over this five-year period; none of the children knew each other and they belonged to different geographical areas. These children presented with a history of hematemesis of varying duration, ranging from a few weeks to two years. The presenting symptoms in all cases included recurrent episodes of bloody vomiting or vomitus simulating blood.

There was an occasional history of abdominal pain; no other symptom was reported by any of the children. Episodes occurred mostly during the daytime, ensuring maximum audience. Most of these children had taken prolonged proton pump inhibitors, and some had even taken H. Pylori eradication therapy prior to coming to us. There were some peculiarities in these cases, like in case number 1 – she initially had vomiting with reddish brown coloured vomitus, followed by vomitus of multiple colours as shown in Figure 1. We initially told her mother (single parent) to remove all drawing colours from the house and give her colouring supplies only under supervision; however, the episodes continued. In subsequent interviews, she said, she was eating her grandmother's tailor chalks from a sewing kit.

In case number 4, she had hematemesis only for 4 to 5 days a month, which we later found out coincided with her time of menstruation. In later interviews, she told us that she was taking menstrual blood to simulate hematemesis. In case number 6, a peculiar dress code was noted; she was seen wearing thick, full-sleeved garments even on hot days, which she refused to remove even for

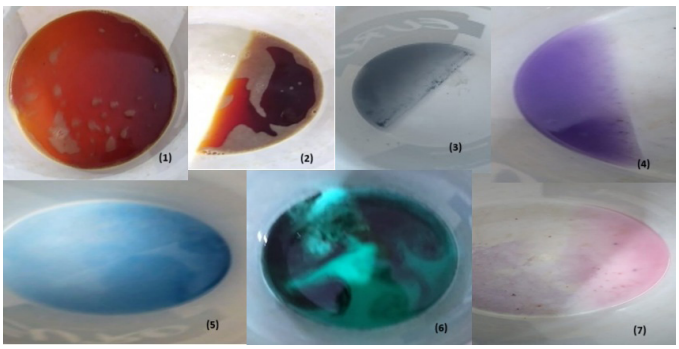

Figure 1: Pictures of vomitus of case 1. Initially reddish brown coloured and subsequently multiple coloured vomitus were seen.

physical examination. Our staff noticed multiple superficial to deep cuts in various stages of healing on her arms and forearms while doing intravenous cannulation for diagnostic procedures. She later told us that these cuts were self-inflicted and that she was sucking blood from these cuts to simulate hematemesis. Another peculiarity noted was that the volume of the vomitus was very little when these children sucked blood from body parts/oral cavity cuts/ epistaxis/dental caries, etc., and the volume was large when fruit juices, etc., were used to simulate hematemesis.

General and systemic examination and all laboratory investigations, including esophagogastroduodenoscopy and otorhinolaryngological examination, were normal in these children. These children had recurrent episodes with no apparent pathology. All these children were told to take pictures of vomitus, giving us a clue that we were not dealing with blood in many cases. There were conflicting accounts of the episodes from these children and their caregivers. Once we had a strong suspicion of FDH, we further interviewed these children and their parents separately, during which all attempts were made to assure them that we understood their difficult situation. When interviewed, these children were extremely confident and initially extremely defiant to all the suggestions of faking hematemesis. They were assured that even if the hematemesis was self-induced, it was a mental health issue (rather than a physical one) that required all the more intense medical care in the form of psychological consultation and even oral medication (anti-anxiety/ antidepressant medication).

All children were heard patiently and after establishing a rapport with the interviewer, accepted that they were inducing hematemesis. All of them had an apprehension that if their family was told about FDH, they would be humiliated, scolded, or hit by their family members. All children were assured that no such thing would happen to them. Following this, the caregivers were interviewed separately and were informed about FDH and the stressors their children were facing. The caregivers were also counselled, and their first reaction was that of denial; all of them assured that they would not humiliate, scold, or hit the child and assured them to alleviate the stressor.

A diagnosis of FD was made by fulfilling DMS-5 diagnostic criteria.[3] All children were evaluated for a comorbid developmental or intellectual disability and all had good intellect. All children perceived their childhood as difficult. They were also evaluated for persistent negative thoughts/ suicide ideation and other features of depression, which were found in cases [3,5 and 8] They were given Fluoxetine orally, in a dose of 10 mg to 20 mg orally once a day for about 2 to 4 months. Initially, these children were called for a follow-up at an interval of one month, in which they were counselled separately and with their parents. Coping techniques for the stressors, long-term life goals ideation, meditation, pranayama and yoga techniques were taught to these children. Two cases had recurrence of symptoms, while all others had no recurrence after a follow-up of one year. All children are under follow-up of the Pediatric Gastroenterology unit and Psychiatry department, and those children who cannot attend physically are regularly contacted telephonically for recurrence of symptoms, and these children are reassured. These children are also a part of a yoga class, which is being conducted regularly online by a senior faculty member in the psychiatry department.

Discussion

FDH presents a significant diagnostic challenge. A high index of suspicion should be maintained when faced with unexplained symptoms despite negative diagnostic findings. When the diagnosis of FDH is made, it is difficult for the caregivers to accept that there is no organic cause for the hematemesis. Additionally, patients with FD can pose a serious physical danger to themselves by inflicting self-injury to induce symptoms [4], as was seen in case number 6. They often eat inedible things like tailor's chalk (case-1) and even menstrual blood (case- 4), to simulate hematemesis.

It is very important to differentiate FD from other closely related conditions like Factitious disorder imposed on another (FDIA), malingering, etc. FD imposed on self is defined as falsification or self-implication of physical or psychological signs or symptoms, or an injury or disease done for the purpose of deception, according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).[3] FD can be differentiated from malingering with the absence of obvious incentive or external reward in FD. Here, patients are purely motivated by so-called "internal or primary gains," e.g., coping with stress, seeking attention, or simply enjoying fooling/baffling the healthcare workers. [5,6] It is important to differentiate FD from FDIA. In FDIA, caregivers inflict some injury to the child to induce medical symptoms in the child, whereas in FD, these symptoms are induced by the child themselves and the caregivers are often taken by surprise by the outcome.

Due to a lack of high-quality studies regarding etiology, no definitive etiology of FD can be demonstrated. The literature suggests that these patients are likely to have a history of major illness during childhood, and an early exposure to the healthcare system might play a role in the development of FD and hence their ability to manipulate healthcare personnel convincingly.[7] They are also likely to have suffered major emotional or physical abuse during early childhood.[8] In our series, four children were being raised by single mothers and six children had marital discord among parents, and all eleven children reported that their childhood was difficult and felt emotional neglect. It also appears that by playing a sick role, these children achieved some kind of affection/care/concern that they were otherwise lacking in their lives. Thus, FD might also be seen as a coping mechanism to deal with stressful life events. These children get a sense of accomplishment in befuddling the health care professionals. FD has been described as a type of addictive behavioural disorder with patients having an uncontrollable urge to keep sick role.[8] These patients might have comorbid depression,[9] three of the children in our series had depression requiring oral medication. All children in our study had excellent intellectual and verbal skills. It is also interesting to note the different substances that these children used to simulate hematemesis, ranging from chalk to fruit juices and even menstrual blood.

These patients often present with complex symptoms, requiring good history taking with a detailed physical exam, which is key to diagnosis. History of inconsistent information/discrepancy in

the history provided by the patient and the caregiver, dramatic presentation of symptoms, inconsistent examination findings and extensive workup/invasive procedures with no definite diagnosis are a few of the clues that may raise the treating physician's suspicion. Confrontation with children, while keeping them in full confidence and assuring them complete confidentiality during the interview, alone gives good results.

Management of FDH with hematemesis involves a multidisciplinary approach, including paediatric gastroenterologists, psychiatrists, dieticians, and social workers. Long-term management of FDH with hematemesis includes counselling and psychotherapy for both the child and the caregiver, focusing on addressing the underlying psychological needs and preventing recurrence.

Conclusion

FDH presents a significant diagnostic challenge due to complex symptoms and normal diagnostic investigations. A high index of suspicion with a detailed interview is key to diagnosis. Management involves a multidisciplinary approach, including paediatric gastroenterologists, psychiatrists, dieticians, and social workers.

Author Contribution

Shruti Sharma: Acquisition of data, interpretation of data, Study concept and design, writing original draft, revising and final approval of the manuscript.

Nidhi Sharma, Yash Pal Sharma, Rashika Thakur: Study concept and design, drafting the article or revising it critically for important intellectual content, and final approval of the manuscript

Mukesh Surya and Sumala Kapila: Study concept and design, drafting the article or revising it critically for important intellectual content, and final approval of the manuscript.

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Ethical statement

All the authors declare that the research presented in this manuscript adheres to the ethical principles outlined by our institute's ethics committee. All procedures involving human participants were conducted in accordance with the ethical standards of our institution (Indira Gandhi Medical College and Hospital, Shimla, HP, India) and the Declaration of Helsinki (1964), as revised in 2013. This manuscript has not been published elsewhere.

Consent to participate

We confirm that approval was obtained from all the children and their parents for participation in this study.

Consent for publication

Informed consent for publication was provided by all the participants. The parents and their children have been informed that there are no identifiable pictures in the manuscript and they have given their consent for the publication of this manuscript.

Data Availability Statement

All the data can be made available on request for research purposes from the corresponding author.

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