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Factitious Disorder Presenting as Recurrent Aortic Emergencies: A Case Report

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Patient: Male, 37-year-old
Final Diagnosis: Factitious disorder • renal artery obstruction
Symptoms: Acute renal failure • feigned bleeding • hypertensive crisis
Clinical Procedure: —
Specialty: Surgery

Objective: Rare coexistence of disease or pathology

Background: Factitious disorder, historically known as Munchausen's syndrome, is a psychiatric condition characterized by the intentional fabrication or induction of symptoms without obvious external incentives. Patients frequently present with dramatic, medically convincing concerns that can mimic life-threatening illnesses and prompt extensive diagnostic evaluations. Although hemorrhagic presentations have been described, presentations mimicking catastrophic vascular disease are uncommon and pose unique challenges for emergency medicine and vascular teams.

Case Report: A 37-year-old man with a subsequently documented diagnosis of factitious disorder repeatedly presented to multiple hospitals with dramatic hematemesis concerning for an aortoenteric fistula. Over an 8-year period, he underwent multiple diagnostic evaluations and several aortic interventions, including endovascular aortic repair and later explantation, despite repeated studies showing no aortoenteric pathology. In 2024, he developed bilateral renal artery occlusions secondary to focal aortic dissection requiring emergent stenting. A psychiatric evaluation at an outside institution ultimately diagnosed Munchausen syndrome. Recurrent presentations across healthcare systems, repeatedly negative diagnostic evaluations, inconsistent objective findings, and family-reported discovery of vials containing a red blood-like fluid provided additional evidence concerning for deliberate symptom fabrication.

Conclusions: This case report shows how factitious disorder can mimic life-threatening vascular disease. While urgent pathology must be excluded, recurrent high-acuity presentations accompanied by inconsistent objective findings should prompt cross-institutional record review, multidisciplinary evaluation, and broader diagnostic consideration to prevent unnecessary procedural escalation and iatrogenic harm, facilitate earlier diagnostic recognition, and support appropriate psychiatric intervention.

Keywords: Factitious Disorders • Aortic Diseases • Renal Artery

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Introduction

Factitious disorder, historically known as Munchausen syndrome, is a psychiatric condition in which patients intentionally falsify or induce symptoms to assume a sick role. These individuals often present dramatic narratives, have numerous prior hospitalizations across multiple sites, and can become confrontational or leave against medical advice [1]. Early diagnosis is difficult in acute settings, where symptoms appear urgent, and clinicians prioritize stabilization. Delayed recognition increases the risk of unnecessary procedures and iatrogenic injury. Long-term management requires multidisciplinary involvement, led by psychiatry, although many patients resist treatment and frequently change providers or clinical sites [2]. This report describes a patient with longstanding factitious disorder who repeatedly presented with symptoms concerning for aortic catastrophe, ultimately undergoing multiple major vascular interventions, including endovascular aortic repair, graft explantation, and bilateral renal artery stenting. This case illustrates how factitious disorder can closely mimic life-threatening aortic pathology and highlights the risk of iatrogenic harm from repeated invasive procedures.

Although factitious disorder has been reported in association with fabricated hemorrhagic symptoms, its presentation as a recurrent vascular emergency is rarely described. This report describes a patient whose factitious presentations repeatedly mimicked catastrophic aortic pathology and resulted in multiple major aortic interventions. As an educational case, it highlights the importance of longitudinal review of records across healthcare systems and early multidisciplinary involvement, including psychiatry, as key safeguards against unnecessary procedures and procedure-related morbidity.

Case Report

A 37-year-old man with a reported history of an aortoenteric fistula presented repeatedly to emergency departments with hematemesis starting in 2017. Despite an 8-year period of evaluations for hematemesis, no imaging or endoscopic study ever confirmed an aortoenteric pathology. His episodes followed a consistent pattern. He arrived at community hospitals describing a remote aortoenteric fistula repair and then produced bright red hematemesis, often dramatically timed during computed tomography. He was frequently intubated for airway protection and transferred to a tertiary center for intensive care unit (ICU) management. Over the years, he underwent dozens of CT scans, upper endoscopies, fluoroscopic swallow studies, and nuclear medicine bleeding studies. None demonstrated active bleeding, fistula, or acute gastrointestinal or aortic pathology. In March 2022, an aortic endovascular stent graft was placed at an outside institution. Contemporaneous outside records

documenting the indication for this procedure were not available for our review. However, given the patient's recurrent presentations with hematemesis and reported history of an aortoenteric fistula, we believe these presentations likely prompted the decision to place an aortic stent graft, although the actual indication could not be independently verified.

In January 2024, he presented again to an outside hospital with hematemesis, severe hypertension (systolic blood pressure of 230 mm Hg), shortness of breath, and a stated history of prior endovascular aortic repair. CT revealed no acute aortic abnormalities. Concerns regarding disproportionate pain led to an emergency laparotomy. Intraoperative esophagogastroduodenoscopy results were normal. The aorta appeared mildly inflamed, prompting explantation of the endograft and subsequent aortic patch angioplasty. Postoperatively, the patient was extubated in the ICU. His creatinine level initially rose to 4.0 mg/dL but improved to 2.17 mg/dL over several days. Assessment during this hospitalization identified a history of trauma, legal issues, and suspected substance use disorder. Family members reported finding vials containing a red fluid resembling blood in the patient's vehicle. The patient initially refused psychiatric evaluation but was subsequently evaluated by psychiatry at the outside hospital, where a diagnosis of Munchausen syndrome was made. The complete psychiatric diagnostic interview was not available for our review, and the available records do not document that the patient acknowledged consciously producing or inducing the reported bleeding episodes. Therefore, although the psychiatric diagnosis and collateral history strongly supported factitious disorder, we cannot independently establish the patient's subjective awareness or intent during each individual presentation.

In February 2024, he presented to our emergency department with witnessed seizure-like activity and was intubated for airway protection. Examination revealed a healing midline laparotomy incision with staples. He was hypertensive with systolic pressures of 160 mm Hg and creatinine levels of 2.0 mg/dL. CT angiography revealed intimal tears in both renal arteries and multifocal bilateral renal infarctions (Figure 1). He was admitted to the ICU for blood pressure optimization but developed oliguria and rising creatinine levels of 3.01 mg/dL within several hours. The patient underwent urgent aortography. The suprarenal fixation struts from the previous endograft remained embedded in the anterior left wall of the aorta. A flow-limiting dissection flap with early bifurcation was observed in the right renal artery. The left renal artery was occluded proximally, with delayed collateral reconstitution and poor parenchymal opacification (Figure 2).

The patient underwent bilateral renal artery stenting using iCast covered stents (Cook Medical, Bloomington, IN, USA). Completion angiography revealed widely patent bilateral stents



Figure 1. Magnified computed tomography angiography image of the bilateral renal arteries. Right renal artery with intimal flap, left renal artery with occlusion, and distal reconstitution. Left kidney with poor opacification.



Figure 2. Initial aortogram with patent mesenteric vessels. Right renal artery (black arrow) with flow-limiting dissection and early bifurcation. Left renal artery (white arrow) with proximal occlusion and distal reconstitution. Poor to no opacification of the left renal parenchyma. Patent infrarenal aorta, ectasia likely due to recent patch angioplasty.

with improved parenchymal enhancement (**Figure 3**). He returned to the ICU in stable condition. Renal function improved steadily, with creatinine levels trending down to 1.5 mg/dL, with robust urine output. Blood pressure was controlled with oral medications, and he was discharged on the fifth postoperative day.

He missed several scheduled follow-up visits but returned to the emergency department 7 months after stenting. During



Figure 3. Completion angiogram showing patent bilateral renal artery stents and patent renal vessels.

this presentation, he was re-hospitalized for recurrent episodes of hematemesis, again requiring endotracheal intubation. CT angiography of the abdomen during admission revealed no rupture, fistula, or acute vascular abnormality, and both renal stents were patent. He was subsequently discharged himself against medical advice. In September 2025, he presented with altered mental status and was diagnosed with encephalopathy of undetermined etiology. His clinical status deteriorated, and he died shortly thereafter.

Discussion

Factitious disorder is challenging to recognize, particularly in vascular surgery and emergency care settings, where symptoms can resemble life-threatening illnesses. Patients often appear genuinely ill, and their presentation can convincingly mimic catastrophic pathologies. Many cases are only recognized retrospectively or by clinicians familiar with the patient's history [3].

The principal educational message of this case report is that factitious disorder can present in a manner indistinguishable

from a vascular emergency. Because conditions such as aortoenteric fistula and acute arterial malperfusion carry a substantial risk of mortality if untreated, clinicians appropriately maintain a low threshold for intervention. However, when recurrent presentations are accompanied by repeatedly negative investigations, review of longitudinal records across institutions and early multidisciplinary assessment become essential safeguards against unnecessary procedural escalation and iatrogenic harm.

Several subtypes of factitious disorders have been described, including acute abdominal, hemorrhagic, and neurologic variants. Hematemesis is a well-documented factitious manifestation, and some patients use blood or blood-like substances to simulate active bleeding [3]. Once the clinical team perceives hemorrhage, a cascade of interventions follows, including intubation, ICU admission, extensive imaging, and sometimes invasive procedures. This momentum is difficult to interrupt, particularly in institutions that have not previously encountered these patients. An early report of Munchausen syndrome parallels the presentation of our case. A young woman presented with hematemesis, abdominal pain, and numerous surgical scars to various hospitals in England, and her feigned illness was not discovered until several years later when a surgical registrar recognized her [3].

In the present case, the patient repeatedly experienced dramatic episodes of hematemesis, leading to numerous evaluations in multiple hospitals. Despite extensive diagnostic work-ups, no imaging or operative evidence confirmed aortic or gastrointestinal pathology. Nevertheless, he underwent major aortic interventions, including endograft placement and subsequent explantation. In contrast, the bilateral renal artery stenting was performed for objectively documented renal artery dissection with renal malperfusion and represented treatment of true vascular disease rather than a response to a factitious presentation. The renal artery pathology developed after multiple aortic interventions and the temporal relationship suggests the altered renal artery anatomy was related to prior intervention; however, a direct causal relationship cannot be definitively established from the available clinical data.

It is important to note that factitious disorders must be distinguished from malingering. Malingering involves intentional symptom production for external gain, whereas factitious disorders are motivated by psychological needs without an obvious external incentive. Although drug-seeking behaviors can coexist, obtaining medications is not usually the primary motive. Many patients appear to be driven by a need for attention, a desire to occupy the patient role, or by unresolved psychological trauma. Additionally, most patients with factitious disorders have concomitant severe psychological disorders, such as personality disorders, depression, and substance

abuse [4,5]. Characteristic behaviors include aggression toward staff, refusal of recommended care, and leaving against medical advice [6]. Few patients receive definitive psychiatric care or achieve recovery [7]. Many patients present to multiple regional hospitals to avoid recognition.

An important limitation in applying the diagnosis retrospectively is that factitious disorder requires intentional falsification or induction of symptoms. In this case, the diagnosis of Munchausen syndrome was made by a psychiatric consultant at an outside institution. The records available to us did not contain the full psychiatric interview or documentation that the patient personally acknowledged producing the apparent bleeding. Consequently, we cannot independently verify his subjective intent during each episode. Nevertheless, several features argue strongly against the alternative explanation that he mistakenly interpreted minor, genuine bleeding as a life-threatening event. Over dozens of CT scans, upper endoscopies, nuclear medicine bleeding studies, and an intraoperative esophagogastroduodenoscopy performed during laparotomy, no bleeding source of any magnitude was ever identified. The hematemesis was recurrent, voluminous, and bright red, frequently timed during imaging, and repeatedly lacked corresponding objective evidence of hemorrhage. The presentations recurred across multiple unrelated institutions, with a highly stereotyped narrative. Finally, family members reported finding vials containing a blood-like substance in his vehicle, a finding difficult to reconcile with an honest misinterpretation of genuine bleeding. Together with the psychiatric diagnosis, these findings raised substantial concern for intentional symptom fabrication. They should not be interpreted as evidence that every prior presentation or subsequent vascular abnormality was factitious; the renal artery dissections and malperfusion described in this report represented objectively documented vascular disease requiring treatment.

These cases pose unique challenges for vascular surgeons. Aortoenteric fistula is a surgical emergency, and delays in its management can be fatal. Therefore, clinicians are conditioned to respond decisively when symptoms resemble those of catastrophic vascular pathologies. In patients with factitious disorder, this reflex can lead to repeated invasive interventions and iatrogenic harm.

This case represents an incremental extension of the existing literature on factitious disorder rather than a fundamentally new clinical entity. Previous reports have described patients with Munchausen syndrome presenting with hematemesis, fabricated hemorrhage, and recurrent hospitalizations that prompted extensive diagnostic evaluation. However, reports within the vascular surgery literature remain exceedingly limited. This case demonstrates how factitious presentations can mimic acute aortic emergencies, leading to major vascular

interventions and their associated risks. In addition, it illustrates the downstream vascular consequences that can arise after prior interventions, including renal or visceral malperfusion requiring complex endovascular repair. Beyond the clinical presentation itself, the case highlights practical challenges in recognition across fragmented healthcare systems, where repeated emergency presentations at multiple institutions can obscure diagnostic patterns until longitudinal records are reviewed. Collectively, these observations reinforce the importance of integrating psychiatric, surgical, and cross-institutional clinical information when evaluating patients with recurrent dramatized presentations.

This case emphasizes several important aspects of the disease. First, a review of electronic medical records across health systems is essential. Cross-institutional documentation revealed a long history of negative evaluations and repetitive presentations. Second, early involvement of a psychiatrist is critical, although it is often resisted. Third, awareness of factitious disorder is essential to prevent unnecessary interventions. Although clinicians must never dismiss a potentially life-threatening condition, recognizing patterns inconsistent with physiologic illness can guide safer and more measured evaluations.

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Conclusions

Factitious disorder rarely presents as a vascular emergency but may closely mimic acute arterial catastrophes, prompting high-risk interventions. Vascular surgeons, trained to act rapidly in time-sensitive scenarios, may inadvertently expose patients to harm when faced with fabricated symptoms. This case highlights the importance of multidisciplinary assessment, careful review of prior records, and awareness of psychiatric conditions that can masquerade as surgical diseases. Improved recognition may prevent unnecessary procedures and facilitate referrals for appropriate mental health care.

Patient Consent

The patient provided written consent for publication.

Declaration of Figures' Authenticity

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