Case Report

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Factitious epistaxis and oral bleeding in a postpartum mother: A diagnostic challenge

Abstract

Background: Bleeding from the nose or mouth is a common reason for seeking care in otorhinolaryngology. It often raises fear of serious local disease, systemic illness, or cancer. In most patients, an organic cause can be found. Rarely, however, is the bleeding self-produced. In factitious disorder, symptoms are created deliberately, not for money or legal benefit, but to occupy the role of a patient. These cases are difficult to recognize. They lead to repeated procedures, unnecessary tests, patient harm, distress within families, and wasted medical resources.

Recurrent nasal or oral bleeding usually warrants urgent evaluation to exclude vascular lesions, hematologic abnormalities, or malignancy of the upper aerodigestive tract. In rare instances, however, symptoms may be intentionally fabricated, as seen in factitious disorder. Such cases are diagnostically challenging and may lead to repeated invasive procedures before recognition.

Case presentation: A 30-year-old woman presented 11 months after delivery of twins with a three-month history of recurrent epistaxis and oral bleeding associated with dysphagia. Multiple prior evaluations, including nasal endoscopy, nasopharyngeal biopsy, upper gastrointestinal endoscopy, and coagulation studies, were unremarkable. Her haemoglobin remained stable despite frequent reports of bleeding.

The discrepancy between symptoms and objective findings prompted supervised inpatient observation. During 48-hour continuous monitoring, no spontaneous bleeding occurred. The patient was subsequently observed applying dissolved orange-coloured multivitamin capsule contents to the nasal and oral mucosa to simulate haemorrhage. Psychiatric evaluation confirmed factitious disorder imposed on self, based on DSM-5 criteria. Supportive psychotherapy was initiated.

Conclusion: Factitious disorder should be considered in persistent unexplained ENT bleeding when clinical findings are inconsistent with reported severity. Early recognition through structured observation can prevent unnecessary procedures and facilitate appropriate psychiatric care.

Close observation, gentle communication, and teamwork across specialities are essential to prevent harm and to ease the burden on patients, families, and clinicians.

Keywords: factitious disorder, epistaxis; oral bleeding, postpartum, diagnostic challenge, munchausen syndrome

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Introduction

Epistaxis is among the most common emergencies encountered in otorhinolaryngology practice, accounting for a significant proportion of outpatient visits and hospital admissions.[1] While most episodes are benign and self-limiting, recurrent or unexplained bleeding necessitates careful evaluation to exclude coagulopathy, inflammatory disease, vascular malformations, or malignancy.[1,2]

Factitious disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), is characterised by intentional falsification or induction of physical or psychological symptoms without any external reward.[3] The behaviour is motivated by a psychological need to assume the sick role rather than by financial or legal gain. In surgical specialities, factitious presentations may convincingly imitate serious pathology, creating a tension between the duty to exclude life-threatening disease and the responsibility to avoid iatrogenic harm. Patients undergo repeated admissions and invasive procedures. Families experience anxiety and exhaustion. Healthcare systems carry unnecessary costs.[3,4]

Even though simulated bleeding has been described in medical and surgical settings, reports involving the upper aerodigestive tract remain infrequent.[5–7] Awareness among ENT clinicians is therefore limited. We present a case of factitious epistaxis and oral bleeding in a postpartum woman and discuss the diagnostic process, structured observation strategy, and relevant psychiatric considerations.

Case report

A 30-year-old woman presented with a three-month history of recurrent nasal and oral bleeding (Figures 1A & B). She described episodes occurring several times weekly, occasionally associated with difficulty swallowing. She was 11 months postpartum following the delivery of twins.

She had sought care at multiple institutions. Nasal endoscopy revealed mild inferior turbinate hypertrophy without an identifiable bleeding point. A nasopharyngeal biopsy performed elsewhere was inconclusive. An upper gastrointestinal endoscopy came back normal. All laboratory investigations, including platelet count, prothrombin

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time, and activated partial thromboplastin time, were within the normal range. Despite repeated reports of substantial bleeding, her haemoglobin levels stayed steady at around 10 g/dL, a finding inconsistent with true recurrent haemorrhage.[2]

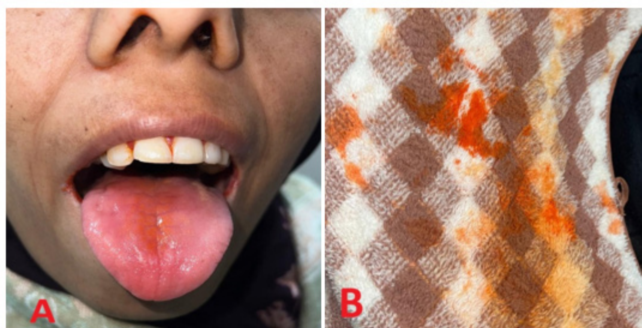

Figure 1 (A) Intraoral photograph showing orange discolouration over the dorsum of the tongue without mucosal ulceration, bleeding points, or vascular lesions. (B) Image of a towel stained with orange-coloured material, presented by the patient as evidence of bleeding.

The patient reported poor sleep and emotional strain related to childcare responsibilities. No formal Edinburgh Postnatal Depression Scale screening had been performed previously. During psychiatric assessment, mild depressive symptoms were noted, but the criteria for postpartum depression were not met.[4]

Given the inconsistency between the reported symptoms and the objective findings, the patient was admitted for supervised observation after obtaining informed consent.

Observation protocol

A structured 48-hour observation protocol was implemented:

- Continuous one-to-one nursing supervision
- Restricted access to personal belongings unless supervised
- Regular inspection of oral and nasal cavities every four hours
- Documentation of all alleged bleeding episodes

No episode of spontaneous bleeding was observed during continuous supervision. Oral and nasal mucosa remained intact. However, during short moments when direct observation was briefly relaxed-like when the patient needed to use the restroom under partial supervision-an orange discolouration was noticed in the oral cavity. It turned out that the patient was seen dissolving orange-coloured multivitamin capsules in water and then applying that solution to both the nasal and oral mucosa (Figures 2C & D).

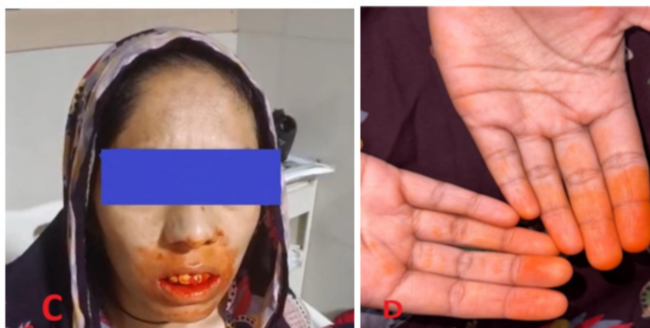

Figure 2 (C) Clinical photograph showing apparent orange-coloured staining around the oral cavity and lips, simulating oral bleeding. (D) Photograph of the patient's palms and fingertips showing orange discolouration.

Further invasive investigations were withheld. The patient was approached in a supportive manner, and a psychiatric consultation was obtained.

Psychiatric assessment

A psychiatric evaluation was conducted. The patient fulfilled DSM-5-TR criteria for factitious disorder imposed on self[2]:

- Falsification of physical signs or symptoms
- Presentation of oneself as ill
- Deceptive behaviour in the absence of external rewards
- Behaviour not better explained by another mental disorder

There was no evidence of malingering or external gain. Supportive psychotherapy was initiated. At the three-month follow-up, no further bleeding episodes were reported.

Discussion

Factitious disorder presents a unique diagnostic challenge, particularly in surgical specialities where symptoms are expected to match objective findings.[1,2] ENT manifestations are rare but include simulated epistaxis, otorrhea, haemoptysis, and non-healing wounds.[5–7] Factitious disorder remains an uncommon but important differential diagnosis in unexplained ENT bleeding. The condition has been systematically reviewed by Yates and Feldman, who analysed 455 published cases and highlighted the high rate of unnecessary medical interventions prior to diagnosis.[8] Surgical specialities are particularly vulnerable to such presentations because fabricated symptoms often mimic acute pathology.

Diagnostic clues

Several features in this case raised suspicion:

- Recurrent bleeding without an identifiable anatomical source
- Normal mucosa on repeated examinations
- Stable haemoglobin despite reported significant blood loss
- Episodes occurring primarily when unobserved

Similar patterns have been described in cases of simulated epistaxis and otorrhea.[5–7]

Role of structured observation

Inpatient observation can be a decisive diagnostic tool. Rather than escalating invasive investigations, correlating symptoms with direct supervision may clarify discrepancies. Previous case reports have emphasised that observation, rather than repeated procedures, often establishes the diagnosis.[6,8]

Keeping a close eye on patients can be a game-changer for diagnosis. Instead of jumping straight to invasive tests, linking symptoms to direct observation can help resolve any inconsistencies. Previous reports have shown that simply observing patients, rather than subjecting them to repeated procedures, often leads to a correct diagnosis.[5]

Observation, thus, remains one of the most powerful tools in such cases. Inpatient monitoring allows symptoms to be correlated with objective findings. It replaces speculation with evidence. In our patient, careful supervision proved more valuable than any scan or scope. Similar observations have been reported in cases of simulated bleeding.[2]

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The postpartum period is associated with hormonal fluctuations, sleep deprivation, and psychosocial stressors.[4] Although factitious disorder is not classified as a postpartum psychiatric entity, psychological vulnerability during this period may predispose individuals to maladaptive illness behaviour. Postpartum psychological distress has been linked to somatic symptom amplification and increased healthcare utilization.[4] In this case, the demands of caring for twins likely intensified the psychological strain and contributed to the behaviour.

For the ENT surgeon, management extends beyond diagnosis. Communication must be careful. Accusation invites denial. Confrontation invites withdrawal.[3] A supportive, non-judgmental approach preserves the therapeutic relationship and allows psychiatric care to begin.[10] Collaboration between otorhinolaryngology, psychiatry, nursing staff, and family members is essential.

There aren't many reports of factitious bleeding in the field of otolaryngology. Some case studies have documented fake ear bleeding and other made-up ENT symptoms.[7,8] However, instances that mimic serious haemorrhaging in the upper aerodigestive tract are quite rare. Raising awareness about this issue could help avoid unnecessary biopsies and repeated endoscopic procedures.

Finally, the burden on families should not be underestimated. Recurrent unexplained bleeding creates fear of cancer, anxiety about survival, and emotional exhaustion.[9] Early recognition protects not only the patient but also those who stand closest to her. Management should focus on safety, empathy, and collaboration. Confrontation is discouraged, as it may result in denial or loss of follow-up.[10]

Limitations

This report describes a single patient with limited follow-up. Psychiatric outcomes beyond three months are unknown. As in many cases of factitious disorder, diagnosis relies on behavioural observation rather than laboratory confirmation.

Conclusion

Factitious disorder should be considered in patients with recurrent nasal and oral bleeding when thorough evaluation fails to identify an organic source. Careful inpatient observation may be the most valuable diagnostic tool. Structured observation, adherence to DSM-5 diagnostic criteria, and multidisciplinary collaboration are central to management. Early recognition prevents unnecessary procedures, reduces emotional burden, and enables timely psychiatric care.

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None.

Conflicts of interest

The authors declare that there are no conflicts of interest.

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