

## Caregiver-fabricated illness in a child prescribed long-term opioids and benzodiazepines

Deepa Kattail, MD, MHS, FAAP; Anne Niec, MD, FRCPC

### ARTICLE INFO

*Keywords:*

analgesics  
opioid  
caregiver-fabricated illness in a child  
Munchausen syndrome by proxy

DOI:10.5055/jom.2020.0562

© 2020 Journal of Opioid Management,  
All Rights Reserved.

### ABSTRACT

*Caregiver-fabricated illness in a child (CFIC) can result in unnecessary, potentially harmful medical investigations and treatment. As pediatric pain has historically been undertreated, the movement for more compassionate treatment has led to an increase in analgesic prescribing in children and adolescents. Overall, this has been a positive change but this may also lead to unintentional harm, particularly if CFIC is not considered as a possibility in the presentation. We present a case in which CFIC was associated with long-term prescribing of opioids, benzodiazepines, and other central nervous system depressants.*

### INTRODUCTION

Caregiver-fabricated illness in a child (CFIC) is “a form of child maltreatment caused by a caregiver who falsifies and/or induces a child’s illness, leading to unnecessary and potentially harmful medical investigations and/or treatment.”<sup>1</sup> Previously referred to as Munchausen syndrome by proxy, factitious disorder by proxy, or medical child abuse, it is fortunately an uncommon diagnosis.<sup>1,2</sup> However, pediatricians must remain vigilant for CFIC when illness is persistently reported without clear etiology and there are ongoing discrepancies among medical history, physical examination, and investigations. Such caregivers often seek a multitude of specialists to pursue investigations and treatment, which commonly results in a complex list of medications prescribed by involved physicians. Out of professional courtesy, most physicians will not adjust or discontinue medications prescribed by another, thus contributing to the potential for inappropriate polypharmacy in a child. We describe a patient who presented to a pediatric chronic pain clinic with a complex medical history including long-term use of opioids and benzodiazepines, who was ultimately diagnosed with CFIC.

### CASE PRESENTATION

An 11-year-old boy was referred to an academically affiliated hospital-based pediatric chronic pain program in the summer of 2017 due to a 2.5-year history of chronic lower back and bilateral leg pain treated with opioids. According to his mother, his pain began following a lumbar puncture during a 3-month admission to hospital in 2015 for investigation of suspected aseptic meningitis with hypersomnolence. During that hospitalization, opioid weaning was attempted but failed because he had an acute flare in his back pain at that time. Despite hypercarbia and oxygen dependency, he remained on combined opioids and benzodiazepines due to fears of medication withdrawal and pain exacerbation. At the time of discharge, he was prescribed several analgesics including extended-release opioids, benzodiazepines, and nonsteroidal anti-inflammatory drugs recommended by the acute pain service. His analgesics were managed by the outpatient pediatric team upon discharge. In 2016, he was referred to pediatric palliative care for pain management (the pediatric chronic pain program was not yet in existence). Due to persistent back pain, analgesics were increased and he was transitioned to methadone

three times daily along with hydromorphone immediate release, celecoxib, methocarbamol, lorazepam, and gabapentin. Because of concerns regarding inconsistencies between parent reports of symptoms, and observed and documented symptoms, the senior author (AN), who is the Director of the Child Advocacy and Assessment Program, was consulted. After several interdisciplinary meetings, it was planned that the patient be admitted to hospital for observation, keeping suspected CFIC on the differential diagnosis. This scheduled admission was delayed until fall of 2017 at the parents' request.

In the summer of 2017, the patient presented to the pediatric chronic pain program as an outpatient for a re-evaluation of chronic back pain requiring long-term opioids. He was noted to be on 28 different medications (Table 1) and his mother confirmed 17 medical diagnoses that were referenced in the medical records available to our team (Table 2). The patient was in a wheelchair and wearing a facemask (reportedly diagnosed with severe immunodeficiency, as per the mother's explanation). His mother described a decline in the patient's functioning, requiring a wheelchair for mobility and diapers for bladder incontinence. During the interview, his mother described her son as sometimes having a respiratory rate of 8 breaths per minute with intermittent oxygen saturation as low as 87 percent at rest. A physical examination without the parents present was completed. Immediately upon separation, the patient stood up from his wheelchair and ran down the hall, kicking, without any appearance of pain or distress. He confided that he did not exercise as his mother "did not allow it," but that he would sometimes sneak into the basement and practice kick boxing without his mother's knowledge. Further examination revealed an obese child who was neurologically normal, including full motor strength, with positive finding of mild back tenderness. Extensive chart review revealed inconsistencies between the mother's history and the opinions of pediatric specialists. Most significant were the neurosurgical notes that detailed a relatively benign diagnosis of epidural lipomatosis that mother frequently stated was life limiting and the cause of her son's neurological decline. The recommendation to the family was to continue with the planned admission and begin a slow wean of all analgesics since the patient had opioid-related side effects (respiratory depression) and persistent chronic back pain despite opioids, and to integrate interdisciplinary management involving physical therapy and psychosocial support around coping with chronic pain.

The patient's in-hospital management included multispecialty assessment, clarification of diagnoses, observation of parental interaction, and polypharmacy wean. Weaning of analgesics and opioids began immediately and was well tolerated. A health care worker was in attendance at all times, and the mother was not left alone with the patient at any time. Parent-child interactions were monitored and documented. All relevant subspecialists (Table 3) were consulted and reviewed the patient's medical diagnoses. During the two-month admission, almost all diagnoses were ruled out; benign spinal epidural lipomatosis, juvenile idiopathic arthritis, and obesity were confirmed. The patient was noted to be active and not dependent on a wheelchair. He presented intellectually much younger than his stated age and had poor social skills. During a meeting with the parents, the primary pediatric team, with a social worker, presented evidence supporting their son's ongoing well-being, including opinions of all specialists, and work-up such as imaging and labwork that ruled out almost all diagnoses that had been reported by the mother. Specifically, the patient was deemed to be healthy without a life-limiting neurological disease, contrary to what was conveyed to him by his parents for several years. His parents had kept him at home much of the time because of his "illnesses," resulting in social and educational isolation and significant deficiencies in his education. However, due to fundraising campaigns and donations, he and his family had participated in a number of excursions.

After consultation with child protective services, the patient was discharged from hospital into child protection custody because of the parents' inability to accept his healthy state and their persistent presentation of him as palliative. At the time of discharge, all medications and supplemental oxygen were successfully weaned and discontinued. While in foster care, the patient's immediate and continued improvements in physical functioning was noted by medical specialists during follow-up. Efforts continue to rehabilitate the patient in terms of his educational deficiencies and physical functioning, including returning to school on a regular basis and functioning without the need for assistive devices such as a wheelchair. At the time of writing, the patient remained in foster care with supervised visits with biological parents. He had returned to school full time, was participating in regular exercise, and remained medication free.

**Table 1. Prescribed medications at the time of pediatric chronic pain referral**

Drug Name	Dose	Route	Frequency
Ariprazole	2 mg	Oral	TID
Ascorbic acid-ascorbate sodium	1500 mg	Oral	Daily
Baclofen	20 mg	Oral	TID
Bisacodyl	5 mg	Oral	Daily PRN
Celecoxib	100 mg	Oral	BID
Cholecalciferol (vitamin D <sub>3</sub> )	2000 units	Oral	Daily
Clobazam	20 mg	Oral	BID
Clonidine	0.05 mg	Oral	Daily every morning
	0.1 mg	Oral	Daily every evening
Dimenhydrinate	25 mg	Oral	Daily PRN constipation
Diphenhydramine	12.5 mg	Oral	Q6H PRN itching
Fluoxetine	20 mg	Oral	Daily
Gabapentin	600 mg	Oral	TID
Hydroxychloroquine	400 mg	Oral	Daily
Ketorolac	20 mg	Oral	Q6H prn pain
Leuprolide	7.5 mg	Intramuscular	Every 30 days
Lorazepam	0.5 mg	Sublingual	PRN for spasms
	2 mg	Sublingual	PRN seizures
Melatonin	10 mg	Oral	QHS prn for sleep
Methadone	2 mg	Oral	TID
Methocarbamol-acetaminophen	400 mg/500 mg	Oral	BID
Montelukast	10 mg	Oral	Daily
Omega 3-dha-epa-fish oil	200-400-1000 mg	Oral	Daily
Pantoprazole	40 mg	Oral	Daily
Phenobarbital	30 mg	Oral	BID
Polyethylene glycol	30 mg	Oral	BID
Ranitidine	150 mg	Oral	Daily
Salbutamol sulfate	100 mcg/actuation	Inhaled	2 puffs Q4H PRN
Fluticasone	250 mcg/actuation	Inhaled	2 puffs daily

Abbreviations: BID, twice daily; PRN, as needed; Q4H/6H, every 4 or 6h; QHS, every evening; TID, three times daily

## DISCUSSION AND CONCLUSION

Caregiver-fabricated illness in a child is a form of maltreatment requiring interdisciplinary communication among clinicians to unravel an often complex and inconsistent presentation. CFIC ranges from

failure to seek medical care on one end of the continuum to deliberately inducing illness on the other.<sup>3</sup> More commonly, CFIC manifests as fabrication of medical history, as seen in the present case. Pediatric specialists frequently operate in silos, allowing caregivers to falsify and disseminate incorrect medical

**Table 2. Medical diagnoses at time of pediatric chronic pain intake**

System	Diagnosis
Central nervous system	Epilepsy
	Autism spectrum disorder
	Spinal epidural lipomatosis
Respiratory	Asthma
	Oxygen dependency
	Obstructive sleep apnea
	Sleep disorder
Immunological	Severe immunodeficiency
Musculoskeletal	Juvenile idiopathic arthritis
	Chronic pain of back and bilateral legs
Gastrointestinal	Gastroesophageal reflux disorder
Psychiatric	Anxiety disorder
	Obsessive compulsive disorder
Miscellaneous	Genetic disorder
	Precocious puberty
	Obesity (body mass index 36.0 kg/m <sup>2</sup> )
	Palliative care designation

information to clinicians, to the detriment of the child. In this case, the patient had been investigated by a number of different pediatric specialties in several locations, resulting in incomplete sharing of information and gaps in the treatment record. The patient had previously been referred to child protective services by a primary care provider for suspicions of abuse, but this was not able to be verified and the case was closed.

It can be very difficult to diagnose CFIC, as the symptoms reported by the caregiver may be absent during the examination, and often when a caregiver does not agree with the diagnosis they may take the child elsewhere for care.<sup>1</sup> Certain disorders are easier to fabricate than others; seizures and asthma are often a presenting feature in CFIC.<sup>3</sup> Our patient was reported by the mother to have both epilepsy and asthma, both of which were confirmed absent on careful examination of the patient and the medical records. However, when the patient presents with a complex medical history it further complicates a diagnosis of CFIC.<sup>2</sup>

**Table 3. Medical specialists involved in care**

Family medicine
General pediatrics
Pediatric rheumatology
Developmental pediatrics
Pediatric immunology
Pediatric orthopedics
Pediatric endocrinology
Pediatric neurosurgery
Pediatric palliative care
Pediatric neurology
Pediatric urology
Pediatric genetics/metabolic disorders
Pediatric gastroenterology
Pediatric respirology
Pediatric chronic pain

In the present case, after noting inconsistencies between the mother's information and the information in the charts, we suspected CFIC and the Child Advocacy and Assessment Program was consulted. The chronic pain program team initiated a comprehensive interdisciplinary intake, where all aspects of the child's life (eg, medical and social) were evaluated. The patient was observed with and without the presence of the parents, and demonstrated remarkably different behaviors when his parents were absent. Particularly, in this case, we noted that the mother was responsible for providing all medical information and organizing appointments for the child; the father was involved in his day-to-day care and was apparently unaware of the fictitious nature of the child's many diagnoses. There are several potential mechanisms and motivations responsible for the need for a caregiver to fabricate illness in a child, including mental health issues, need for attention, drug seeking, and material gain.<sup>3</sup> In this case, we focused solely on the child and were not able to investigate the parents regarding motivation; however, we did become aware of GoFundMe campaigns, involvement in the Make-a-Wish Foundation, and Habitat for Humanity housing and speculate that material gain was at least part of the underlying motivation to continue with the

fabrication. There was no indication that the parents were diverting the opioids for sale, but were instead administering them to the child.

As the caregiver persists in seeking treatments for their child, polypharmacy may result with various teams prescribing medications. When such polypharmacy involves medications that are known to have significant side effects, such as opioids, CFIC can cause significant harm. Pain in the pediatric population is often reported as being undertreated.<sup>4</sup> A review of chronic pain in children and adolescents noted that chronic pain is prevalent,<sup>5</sup> and the past few decades have resulted in more compassionate prescribing of analgesics to children.<sup>6-8</sup> Nonetheless, clinicians must prescribe opioids carefully, reserving their use for selected cases when all other therapies, such as nonopioid analgesics and behavioral coping strategies, are ineffective. Our patient was prescribed pain management medications (opioids, benzodiazepines, nonsteroidal anti-inflammatory drugs) by the acute care service, which was to be subsequently managed by outpatient services. In this case, the medications were not expected to have been continued for many years, and part of the abuse aspect was mother continuing to seek medications.

The present case reveals the detrimental intersection of CFIC and compassionate prescribing of opioids and benzodiazepines in a child, resulting in iatrogenic dependence and respiratory depression. Thorough chart review is essential when assessing a new patient, especially if there are any inconsistencies between reported and written notes. This case also highlighted gaps in medical care that are a result of various teams working in silos and not collaborating in the care of complex patients.

#### ACKNOWLEDGMENT

*We thank Sara Miller MSc, Scientific Editor, Department of Anesthesia – Research Office, McMaster University, Hamilton, ON for editing this manuscript.*

**Funding:** No funding was secured for this study. The authors have no financial relationships relevant to this article to disclose.

**Conflicts of Interest:** The authors have no conflicts of interest relevant to this article to disclose

**Author Contributions:** DK and AN were equally responsible for drafting and revising the case report. Both authors have approved the final version to be published.

*Deepa Kattail, MD, MHS, FAAP, Assistant Professor, Department of Anesthesiology, McMaster University, Hamilton, Ontario, Canada; McMaster Children's Hospital, Hamilton Health Sciences, Hamilton, Ontario, Canada.*

*Anne Niec, MD, FRCPC, Professor, Department of Pediatrics, McMaster University, Hamilton, Ontario, Canada; McMaster Children's Hospital, Hamilton Health Sciences, Hamilton, Ontario, Canada.*

#### REFERENCES

1. Flaherty EG, MacMillan HL, Committee on Child Abuse and Neglect: Caregiver-fabricated illness in a child: A manifestation of child maltreatment. *Pediatrics*. 2013; 132(3): 590-597. doi: 10.1542/peds.2013-2045.
2. Petska HW, Gordon JB, Jablonski D, et al.: The intersection of medical child abuse and medical complexity. *Pediatr Clin North Am*. 2017; 64(1): 253-264. doi: 10.1016/j.pcl.2016.08.016.
3. Bass C, Glaser D.: Early recognition and management of fabricated or induced illness in children. *Lancet*. 2014; 383(9926): 1412-1421.
4. Birnie KA, Chambers CT, Fernandez CV, et al.: Hospitalized children continue to report undertreated and preventable pain. *Pain Res Manag*. 2014; 19(4): 198-204. doi:10.1155/2014/614784.
5. King S, Chambers CT, Huguet A, et al.: The epidemiology of chronic pain in children and adolescents revisited: A systematic review. *Pain*. 2011; 152(12): 2729-2738. doi: 10.1016/j.pain.2011.07.016.
6. Friedrichsdorf SJ, Sidman J, Krane EJ: Prevention and treatment of pain in children: toward a paradigm shift. *Otolaryngol Head Neck Surg*. 2016; 154(5): 804-805. doi: 10.1177/0194599816636100.
7. Schechter NL: The undertreatment of pain in children: An overview. *Pediatr Clin North Am*. 1989; 36(4): 781-94.
8. Weisman SJ, Bernstein B, Schechter NL: Consequences of inadequate analgesia during painful procedures in children. *Arch Pediatr Adolesc Med*. 1998; 152(2): 147-149.