

Case Report

Lasthenie de Ferjol syndrome in child: Is it possible?

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A 13-year-old Moroccan girl was referred to our department because of profound asthenia, palpitations and dyspnoea after very moderate effort. Over the past two years, she had been repeatedly admitted to various hospitals for severe anaemia. The most recent hospitalization had ended two months ago before our observation. Iron, vitamin B12, and folic acid had been prescribed without any amelioration. Her family and social history contained nothing relevant. On admission, the patient's skin and mucosae were extremely pale and dehydrated. Subcutaneous fat was reduced, and there was no evidence of jaundice or edema. The conjunctiva showed anemia, but ear, nose, and throat examinations showed nothing unusual, and there was no lymphadenopathy. The heart and lungs were unremarkable, and abdominal examination indicated no hepatosplenomegaly, masses, or tenderness. The results of neurological examination were normal. Venipuncture marks and ecchymosis in the right antecubital fossa were noted. Numerous inconclusive investigations were undertaken in an attempt to clarify the cause of the persistent anaemia.

Initial laboratory results revealed hypochromic, microcytic, iron-deficiency anaemia (RBC 2,600,000/mm³, Hb 3.8 g/dl, Hct 25%, MCV 63μ³, M.C.H.C 29%, reticulocytes 0.9%, iron 25 μg/ml, serum ferritin 6 ng/ml) with normal white blood (5300/mm³) and platelets count (197,000/mm³). The bone marrow was hypercellular with erythroid hyperplasia. Serum vitamin B12 and folate levels were normal. Serum glucose, blood urea, creatinine, bilirubin, lactate dehydrogenase, liver enzymes and serum electrolytes were within normal limits. Bleeding, clotting and prothrombin times were normal. Direct Coombs test was normal. Chest radiography was unremarkable. There was no evidence of hemoglobinopathy and multiple stool specimens were negative for occult blood. Upper and lower gastrointestinal endoscopic examinations revealed no abnormalities, and no gynaecological disorders were found. These results were consistent with a diagnosis of iron deficiency due to blood loss. The patient was immediately transfused with packed red cells (two units). The physician considered the possibility of factitious anemia

and interviewed the patient accordingly.

The patient confessed that she conducted self-blood drawing. Therapy was then continued with intravenous iron, folic acid per os, and vitamin B12 IM. After ten days, the hemoglobin level had increased to 10.8 g/dl. The self-injurious behaviour was interpreted as depression-related and the patient was told of the conclusions of our investigation and addressed for psychiatric treatment. She was discharged on psychotherapy with outpatient follow-up. Three months later, a routine check-up revealed no evidence of anaemia. She told us that, with the help of psychotherapy, she had improved considerably. Indeed, she appeared much more self-confident than she had during the previous admission.

Iron-deficiency anaemia in child is usually secondary to blood loss. In many cases the cause and site of blood loss are not established even after full clinical examination and investigation. Iron administration generally improves the anaemia. Only a small number of cases of factitious anaemia have been reported in the medical literature. The first case was reported by Daily et al. (1963). Lasthenie de Ferjol (LF) syndrome is a very rare psychiatric pathology characterized by severe relapsing anaemia due to repeated self-induced hemorrhages. It was named after the heroine of a Barbey D'Aurevilly novel, who bled to death after piercing herself with eighteen needles to expiate the 'sins' of her rape and pregnancy (Bernard et al., 1967). The symptoms are unusual, and they develop only when the patient is alone and unsupervised. They usually worsen during therapy, and relapse after an initial period of improvement is common. The diagnosis usually is difficult, and many cases are diagnosed only after long-term hospitalization and numerous evaluations. Patients with factitious illnesses "need to be sick," and they are constantly in search of new hospital admissions and/or medical examinations. Most patients reported thus far are females who work in medical settings. The true etiology of the illness is very difficult to diagnose, and the prognosis is usually poor.

The microcytic anaemia observed in a patient with LF syndrome is non-specific, reflecting only chronic blood loss.

The diagnosis is based on the findings of anaemia together with a singular psychological history (Alby, 1982). The blood-letting indulged in by LF syndrome patients is a regular and sometimes ritualized practice, an obsessive act. The methods used to provoke blood loss vary widely from one patient to another and include venipuncture with syringe aspiration, self-inflicted bladder or vaginal trauma, and, in rare cases, repeated blood donations in different centres (Eisenfiz et al., 1988). The same patient may also use different techniques to avoid being discovered. Somatic therapy based on blood transfusions and iron (IV, IM, per os) and vitamin supplementation is palliative. Psychotherapy is the most useful approach, and it should begin as soon as possible to prevent the illness from becoming chronic or even lethal. The feeling of exposure often leads the patient to break off all relations with the physicians that have diagnosed the real problem and move on to another hospital or outpatient clinic. Physicians who see these patients are generally unaware of the ongoing nature of the illness.

Evidence of multiple relapses should raise the suspicion of this syndrome, which is admittedly rare but frequently carries a negative prognosis. A psychiatric consultation should be arranged as soon as possible. In LF the doctor-patient relationship is frequently altered. As a result, it is very difficult to carry out an effective therapy. The goal of psychotherapy is to modify the patient's thought systems and behaviour. Pharmacotherapy is generally not advised although some authors indicate that pimozide or serotonin reuptake inhibitors may be of benefit (Prior and Gordon, 1997). In most cases, however, the results of drug therapy are very poor. Relapses are extremely common and death is often the outcome. In conclusion, the LF syndrome should always be considered in patients presenting with recurrent unexplained anaemia.

Patients with this syndrome frequently end up on general medical wards under the care of haematologists, but a psychiatric work-up should be arranged as soon as the possibility of factitious blood-letting is suspected. To our knowledge, it is the first case of LF reported in a child.

REFERENCES

- Daily WJ, Coles JM, Creger WP (1963). Factitious anaemia. *Ann. Intern. Med.* 58:533-538.
- Bernard J, Najean Y, Alby N, Rain JD (1967). Les anémies hypochromes dues é des hémorragies volontairement provoquées syndrome de Lasthénie de Ferjol. *Presse Med.* 75:(20) 87-90.
- Alby N (1982). Syndrome de Lasthénie de Ferjol: étude psychologique. *Actual Hématol.* 15:121-125.
- Eisenfiz M, Chabolle F, Ferreri M, Meyer B, Chouard CH (1988). Oropharyngeal form of the Lasthénie de Ferjol syndrome. A propos of a case. *Ann. Otolaryngol. Chir. Cervicofac.* 105(3):193-197.
- Prior TI, Gordon A (1997). Treatment of factitious disorder with Pimozide. *Can. J. Psychiatry.* 42(5): 532.