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Прогрессирующая потеря зрения как проявление синдрома Мюнхгаузена на примере клинического случая

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АННОТАЦИЯ

В статье представлен клинический случай синдрома Мюнхгаузена с жалобами на прогрессирующее снижение зрения, ранее не описанный в отечественной литературе. В рамках исследования были проведены обзор современной литературы по данной тематике, психопатологическое обследование пациентки, анализ медицинских данных обследований вовлечённых специалистов. Рассмотрены существующие трудности в диагностике данного синдрома, в том числе с учётом особенностей офтальмологической практики, и сделан вывод о необходимости повышения настороженности врачей всех специальностей в отношении случаев поддельных симптомов в целях адекватного ведения таких пациентов и предотвращения назначения необоснованных потенциально вредных медицинских вмешательств.

Ключевые слова: *синдром Мюнхгаузена, имитированное расстройство, функциональное нарушение зрения, неорганическое нарушение зрения, междисциплинарная диагностика.*

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Progressive vision loss as part of Munchausen's syndrom on the example of the clinical case

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ABSTRACT

The article presents a case of Munchausen's syndrome featuring complaints of progressive vision loss not previously reported in Russian literature. Within the research scope, we performed psychopathological enquiry, analysed the medical examination records of the involved specialists, as well as review of modern literature. Existing obstacles in the diagnostics of the syndrome in question were investigated including particularities of ophthalmological practice and it is concluded that alertness of doctors of all specialties in respect of feigned symptoms cases should be increased to properly manage such patients and prevent prescription of unnecessary potentially harmful medical interventions.

Keywords: *Munchausen's syndrome, factitious disorder, functional visual loss, nonorganic visual loss, interdisciplinary diagnostics.*

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INTRODUCTION

The manifestation of psychiatric disorders as somatic complaints is a significant challenge for internists and psychiatrists. Munchausen's syndrome was first described in the mid-20th century by Richard Asher, who identified a heterogeneous group of patients presenting with frequent and pronounced somatic complaints, along with a constant need of medical care [1].

In current understanding, this syndrome is more commonly categorized within factitious disorders of any degree of severity [2–4] or only in the most extreme forms of its manifestation [5]. Recognizing and differentiating this disorder from related diseases pose significant difficulties for physicians. This is the reason behind significant differences in the estimates of its prevalence, i.e., from 0.02% of patients in specialized clinics [6] to 6% of the studied group of patients [7], while the most generally accepted estimate (including the estimate according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition) is approximately 1% of treated patients [8–10].

Risk factors for factitious disorder include female gender, association with the medical profession [5, 11], young age, and the presence of a personality disorder or depressive disorder [11].

The development of diagnostic classifications of factitious disorders and their differentiation from related categories is a separate problem which is frequently reported in the literature [11–13].

The International Classification of Diseases, 11th revision (ICD-11), characterized "factitious self-disorder" (6D50) with an explicit specification to include Munchausen's syndrome as the feigning, falsification, or provocation in oneself of somatic, psychological, and behavioral symptoms or aggravation of symptoms of an existing disorder, supported by established evidence of feigning and motivated by various goals. In addition, the ICD-10 for "faking disorder" (F68.1) specifies this condition as a disorder of patient role-taking, often associated with marked abnormalities of personality and relationships.

In contrast to Munchausen's syndrome, external rewards or goals serve as only obvious motivation in simulation. Involuntary, unintentional disturbances in behavior, psyche, and the holistic functioning of various personality domains characterize dissociative disorders. Somatized disorders involve the presence of multiple and variable somatic sensations that persist over a long period. Hypochondriacal disorders are primarily characterized by the patient's persistent worry or fear about the mere fact of having a serious, progressive, or life-threatening illness.

Patients with a factitious disorder are more likely presented to somatic medical facilities, although some studies concluded that the frequency of simulated psychiatric symptoms may be underestimated [11]. Typologically, gastroenterologic, cardiologic, or neurologic disorder variants are the most common. In addition, ophthalmologists encounter such patients, which are almost neglected in the current Russian literature.

The relevance of this problem is confirmed by several international publications on psychopathological aspects of vision loss [13–16] and within the framework of a comprehensive consideration of etiology, diagnosis, and treatment of functional (inorganic) vision loss [17–19]. The diagnosis of functional vision loss is currently considered an inclusion diagnosis [13, 16, 18], which requires, exclusion of organic pathology along with the objective confirmation of the nonphysiological nature of the subjective symptoms reported by the patient during the ophthalmologic examination.

However, co-management of the patient with a psychologist and psychiatrist is both recognized [13, 15] and denied by some authors [17] because psychopharmacological and psychotherapeutic methods of treatment of the factitious disorder have proven inefficient [20]. The preferred therapeutic approach is nonconfrontational reassurance of the patient in a favorable prognosis and inevitable gradual full recovery of vision [17, 19].

Therefore, the complex interrelationships between organic and inorganic (mental) pathology should be emphasized separately. First, the mental state affects the assessment of somatic sensations and abilities (including visual abilities). Visual impairment, in turn, negatively affects the patient's mental state. Second, inorganic and organic causes of visual impairment (e.g., side effects of psychopharmacological drugs, strokes, neoplasms of the central nervous system, and

neurodegenerative diseases) may coexist, leading to functional overlap of symptoms [13, 17–19]. Additionally, the conclusion about the functional nature of visual impairment may sometimes be incorrect due to errors in the diagnostic process and imperfections of modern criteria and instrumental methods of diagnosing certain diseases [13, 18].

The literature generally needs more clear data on the epidemiology, diagnosis, therapeutic management, and prognosis of the factitious disorder. The syndrome often remains undiagnosed, and patients are characterized by deficient compliance and are virtually immune to controlled studies. For the same reason, most scientific papers on this topic are mainly devoted to reviewing new or previously published clinical cases [11].

Studies conducted outside Russia reported separate clinical observations of patients with ocular Munchausen's syndrome [21–25]; however, detailed reports of such observations in Russian clinical practice were not available until now. The clinical case presented in this study presents essential practical information for ophthalmologists, and emphasizes the peculiarities of mental status and the risk of manifestation of comorbid psychiatric disorders during catamenial observation for psychiatrists.

CLINICAL CASE

Patient D., an 18-year-old female, was consulted with her voluntary consent by psychiatrists on the referral of ophthalmologists due to the suspected psychopathological nature of her complaints of visual impairment.

Medical history (according to the patient and her mother). The patient had family history of mental illness including schizophrenia in grandfather's brother and commitment of suicide by father's sister. The patient was born from her first pregnancy, and pregnancy and birth were normal. No peculiar symptoms were noticed during childhood and school-age. She attended kindergarten and started school at 7; her school performance was "good" and "excellent." She has a 6-year-old brother. Both mother and father are working and had high educational qualifications. Her grandparents are doctors by profession and are actively involved in the patient's life, so the environment of her upbringing can be characterized as "medical." At the time of the consultation, D was in the 11th grade and was planning to enter medical university.

Menstruation started at the age of 12 years and was irregular and painless. Her past and present somatic diseases are mild myopia, arterial hypertension, retinal angiopathy, chronic gastritis, chronic pyelonephritis, pancreatitis, salmonellosis, pneumonia, and shoulder dislocation. The patient's mother notes her daughter's complaints of allergies exclusively to her grandmother's dog.

Ophthalmic history. The patient states that the first complaints of visual impairment occurred at the age of 10, when accommodation spasm was first diagnosed, and atropine instillations were prescribed. At the age of 16, during inpatient treatment in the gastroenterology department for pancreatitis in March 2021, the patient suffered a hypertensive crisis with loss of consciousness and subsequent complaints of decreased visual acuity and narrowing of the visual field of the right eye.

The patient noticed the onset of visual disturbances in the left eye six months after another hypertensive crisis. Decreased conduction of optic nerves, according to an electrophysiological study, was registered.

After 10 months, the spherical component of myopia was −11 D in the right eye and −10 D in the left eye; the visual field was narrowed to 10° in the right eye and 30° in the left eye. According to the examination results, the accommodative spasm was diagnosed with a slight effect of atropine instillations, which decreased more and more at each subsequent visit to the ophthalmologist.

In November 2022, the patient was admitted to the cardiology department with another hypertensive crisis. The day after hospitalization, a spontaneous dilation of the pupil of the right eye without response to instillations of m-cholinomimetics was noted.

In December 2022, computed tomography of the adrenal glands revealed a focal mass, but its hormonal activity was subsequently ruled out by the endocrinology department. The medical staff found prescribed antihypertensive medications under the patient's bed mattress, which the patient had not taken. The attending physician opted for infusion

therapy using isotonic sodium chloride solution under the guise of antihypertensive drugs, which led to the normalization of blood pressure. Subsequently, D sought the help of a psychotherapist to adjust to life without vision, and refused to undergo a medical and social expert evaluation to determine the disability group.

In February 2023, the patient was admitted to a scientific center in Moscow with complaints of loss of vision. Upon admission, visual acuity in the right eye and left eye was equal to light perception and to counting fingers from 15 cm, respectively. During hospitalization, the patient noticed spontaneous dilation of the left pupil. The diagnosis was made: "Main diagnosis: OU: descending partial atrophy of the optic nerve. Associated diseases: vegetative-vascular dystonia of mixed type. Paresis of accommodation." Conservative treatment (OU retrobulbar solution of 0.4% dexamethasone solution 0.3 ml #3) was performed.

Examination by an ophthalmologist in March 2023 revealed zero visual acuity in the right eye and finger counting in the left eye from a distance of 10 cm. During the observation of the patient's behavior, the subjective nature of the complaints was suspected on the basis of the detected features, i.e., good orientation in the environment, untypical for visually impaired, highly organized behavior at home, and clear orientation to the mark during optical coherence tomography of the optic disc. The patient's family members found a hidden open ampoule of 0.1% atropine sulfate solution, which could cause paresis of accommodation and mydriasis.

At the end of the same month, the patient reported that her vision recovered spontaneously. Thus, the spherical component of myopia in the right and left eyes was −1.5 D and −0.5 D, respectively, and the visual fields and optic nerve lability were normalized.

Neurologic history. The patient underwent a neurological examination in July 2022. Magnetic resonance imaging (MRI) of the brain showed evidence of a low position of the right cerebellar amygdala. The MRI of cerebral veins and cerebral arteries revealed slight asymmetry of venous blood flow and vertebral arteries. Following this, a neurologist diagnosed the patient with hypertensive-type cerebral angiodystonia, cerebroasthenic syndrome, and vestibulopathy. In December 2022, an additional contrast-enhanced MRI of the brain was conducted, revealing signs of mild dislocation of the right cerebellar amygdala into the greater occipital foramen, cystic transformation of the pineal gland, moderate asymmetry of the intracranial sections of the vertebral arteries, and mild perineural edema of the optic nerves (indirect signs of intracranial hypertension).

Experimental psychological examination. In May 2023, the patient was examined by a clinical psychologist. During the conversation, she tended to conceal her primary slight stiffness with a slightly impulsive, outwardly free, and smilingly awkward behavioral style. During testing, the demonstrative-epathetic tendency prevailed, with occasional negativism. There were occasional episodes of increased concentration, which, for a few seconds, gave the patient's facial expressions a somewhat autistic tone. Her attention was at a sufficient level with slight instability of concentration due to elements of transient hyperstenic asthenization: 44"–35"–56"–59"–46," according to Schulte's tables. Her direct memorization at the borderline level was 4-7-7-5-7 words out of 10. The mediated memorization was sufficient.

Simple analogies and assessment of the correctness of basic logical operations were mostly performed correctly. However, in other tasks, where the absence of external criteria of logicality was combined with increased cognitive uncertainty, actively and with pleasure looked for odious solutions that would convey the themes of damage, destruction, and death. In working with the five tasks of the Discrimination of Concept Properties test, indicated three times as many latent features as is acceptable for psychiatric norm and borderline conditions. The frequent use of unusual and threatening themes, latent features, and sometimes elements of systematization on the basis of increased mediation argued that "otherwise it would not be interesting."

Differences in the levels of assessment of personality studies (Tables 1 and 2) were mainly associated with fluctuations in affective background and technical test features. However, the main features of the profiles obtained were similar. The data of the control scales indicated an excessive desire to draw the attention of specialists to significant difficulties in adaptation and problematic aspects of personality, with little

Table 1. Results of the standardized multifactor personality study

L	F	K	1	2	3	4	5	6	7	8	9	0
36	166	39	81	74	73	82	66	**112**	**83**	**118**	80	68

Table 2. Results of the abbreviated multifactor personality questionnaire

L	F	K	1	2	3	4	6	7	8	9
38	81	33	75	70	66	77	**80**	**66**	**81**	74

interest in the consistency of one's own interests with the expectations of the reference environment.

Aggravating accents made the levels of assessments of the main scales questionable, but the resulting profiles structure often relates to a tendency to subjective rigidity in organizing one's activities with an emphasis on own priorities and a readiness to embody these with a persistence that reaches cruelty, and not much to intentional distortions.

Strong inhibition of spontaneous behavior was combined with high neuroticism and sensitivity to unconditional aggressive stimuli with hard-to-control activation of "fight and flight" urges. Against this background, the patient showed pronounced emotional instability, anxiety, and suspicion toward emotionally close relationships. The patient insisted on her uncompromising decisions and pursued independence from both external influences and intrapersonal conflicts. Her temporary blindness was projected as an attempt to compensate for the lack of understanding and confidence in her own safety by radical means, as a preference for absolute peace and the absence of problems over her sense of helplessness and rebellion.

The test and nontest data revealed a sufficient level of attention and memory, preservation of the ability to construct logic in clearly structured situations, and numerous overly subjective interpretations in situations of increased uncertainty, as well as strong attempts by the personality to radically free itself from fears and contradictions within itself and emotionally close relationships.

Mental status. The patient regularly visited a psychiatrist during the first half of 2023. She appeared neat, well-dressed, and groomed long hair. Slightly increased diet was reported. Mimic was expressive, mostly friendly, and smiled a lot. However, with this upbeat mood, caution could be detected, depending on the content of the questions asked. Moreover, at the end of one of the interviews, she became extremely tense, wrinkled her nose, looked ahead, became unresponsive to external stimuli, and then politely but very briefly and inarticulately said goodbye. Motor sphere did not show any peculiarities. The speech was loud, intelligible, and well-modulated, and the pace was normal. Attention was sufficiently aroused and maintained. Orientation was correct in all types.

The patient's mother agreed that her daughter is always smiling and often in a good mood, suggesting that she tends to keep her negative feelings to herself.

The patient reported not having any close friends. She dated a young man for a while and "liked him to like her" but was disgusted by any physical intimacy. She was often rude to him, hit him in the face with a book and broke his glasses. She loves dogs but claims not to work as a veterinarian because it requires too much responsibility. However, she plans to become a pediatrician, as she has no particular love for children —"children are not pitiful"; "they haven't lived long enough, they don't understand anything."

When asked if she accepted her appearance, the patient thoughtfully replied, "Now I do." She recalled that when she was 15 years old: she took 10 furosemide tablets and 10 senadexin tablets to lose weight, influenced by information from the Internet. She called this act rash: "I could have killed myself." She reluctantly reported repeated instances of self-harm. She explained this behavior by saying that she was "probably trying to turn emotional pain into physical pain."

Recalling the episode of vision loss, the patient stated being very worried at the time, "sobbing," and fearing its recurrence: "I won't be able to live through it." However, she was also in good spirits at the time of the imagined vision loss and did not present with any anxiety–depressive spectrum complaints during her communication with the psychiatrist.

When assessing the impact of the visual impairment on daily functioning, it was observed that she experienced almost no negative consequences. She successfully managed all the needs of self-care and mobility, as well as continuing her education (with the use of audio equipment). While explaining in general terms the inability to see surrounding objects, she simultaneously paid attention to the doctor's appearance (explaining it by the ability to see "images") and immediately recognized him at the second consultation after her vision was restored.

In general, when presenting specific requests for medical care, the patient rarely expressed or self-reported substantive complaints, preferring to engage in conversations by asking and answering questions with interest. At times, she openly and flirtatiously mused aloud, admitting incomplete honesty in conversations with doctors ("Okay, I can't talk about that."). Her statements and explanations were not thoughtful and elaborate and were often largely one-step and situational in nature. She displayed embarrassment at being reminded of some of her own previously self-reported information, marveling at the doctor's awareness. Similarly, she struggled to consistently describe the dynamics of her visual symptom relief, limiting herself to saying that she was willing to try every treatment modality from psychological counseling to retrobulbar dexamethasone injections, "it all worked together"; she was asked to believe in rapid visual recovery, and it eventually came.

DISCUSSION

Following main features of the clinical case can be distinguished after analyzing the above data:

1) long history of somatic complaints, including gastroenterological (pancreatitis), cardiologic (arterial hypertension with a crisis course), ophthalmologic (accommodative spasm, mild myopia), and neuro–ophthalmologic (partial optic atrophy) profiles;

2) persistent orientation to medical care, including various examinations and invasive and potentially dangerous types of medical intervention (retrobulbar injections);

3) conscious imitation of symptoms up to deliberate provocation of symptoms (instillation of atropine sulfate solution);

4) spontaneous and complete disappearance of all reported symptoms with no interest on the patient's part in understanding most effective of method;

5) absence of symptoms of pronounced depressive–anxiety disorders, inconsistency of elevated mood background with the claimed degree of functional decline;

6) presence of signs of personality disorders according to the data of experimental psychological and pathopsychological examinations (separate features of schizoid, hysterical, and emotionally unstable types); and

7) absence of pronounced functional impairment and clear interest in interaction and adaptation within the claimed limitations.

The correspondence of these features to possible nosologic categories within ICD-10 and ICD-11 will be considered sequentially.

According to ICD-10 (F44), dissociative (conversion) disorders, suggest the presence of psychogenic causation in the form of a clear temporal link to stressful events, problems, or disturbed relationships. The description of dissociative movement and sensation disorders (F44.4–F44.7) specifies that such a link to psychological stress may not be present. Moreover, the loss of function is not under voluntary control and results in decreased productivity, which helps the patient in avoiding conflict, express dependence or resentment, and attract attention. In dissociative anesthesia or loss of sensory perception (F44.6), there is rarely a total loss of vision, but is often manifested by reduced visual acuity, its general obscuration, and narrowing of the visual field, while the patient's motor productivity remains good.

Similarly, the ICD-11 description of dissociative disorders (block L1-6B6) refers to the involuntary nature of the disturbance or disruption of the holistic functioning of various domains, while dissociative disorder with neurological symptoms and visual disturbances (6B60.0) may include conditions, such

as blindness, tunnel vision, diplopia, visual distortions, and hallucinations. The dissociative symptoms are severe enough to cause significant impairment in personal, family, social, academic, occupational, and other important areas of daily life functioning.

In this case, no evidence of a provoking stressful event was available. The decrease in visual function was obviously of a deliberate conscious nature. Despite its significant severity, it did not lead to any maladaptation of the patient, which allows excluding this diagnosis.

Simulation is included in both ICD-10 (Z76.5) and ICD-11 (QC30) under "Factors affecting public health and health care utilization." As an ICD category, simulation is not a disease in its own right, let alone a mental illness. Simulation is characterized by an exclusive focus on obtaining socially understandable, often material, and generally accepted external benefits. The peculiarities of this case do not allow speaking about simulation, because the pathological behavior was not aimed at obtaining any material benefits. The patient displayed no interest in obtaining a disability group and calmly continued to perform all her personal, family, and educational duties.

Somatization disorder (F.45 in ICD-10) involves the presence for at least 2 years of multiple and variable somatic symptoms (more often gastrointestinal or cutaneous) for which no adequate somatic explanation was found. This condition is accompanied by constant demands for medical care, decreased social functioning, and often marked depression and anxiety. The patient demands elimination of the somatic symptoms, resists attempts to discuss the possibility that they are psychologically related and often overuses medication.

The ICD-11 physical distress category (6C20) is characterized by the presence of physical sensations that are highly distressing to the individual and are the focus of excessive attention, as manifested by repeated requests for medical attention. The somatic symptoms are multiple, fluctuating, and unpleasant sensations that occur on most days over several months and can interfere with the individual's functioning.

Despite patient D's persistent demands for medical care, the reported symptoms were not multiple, variable complaints aggravated and provoked by the patient. These symptoms resolved spontaneously without a clear understanding of effective treatment and did not significantly interfere with functioning. In addition, the patient did not focus her and the clinicians' attention on the symptoms, was engaged in the interview process, and did not exhibit depressive–anxiety disorder.

Hypochondriacal disorder (F45.2 in ICD-10) is characterized by persistent beliefs in the existence of one or more serious somatic illnesses and persistent distrust of various physicians who try to convince the patient that no somatic illness exists. Severe depression and anxiety are often present, and the degree of decreased productivity is highly variable. Patients tend to be more concerned about the disease itself and its consequences rather than individual symptoms. They seek reassurance through frequent visits to different physicians, asking for tests to confirm the nature of the suspected illness, rather than treatment for fear of medication side effects.

In ICD-11, hypochondria (6B23) is characterized by persistent worry or fear about the possible presence of one or more serious, progressive, or life-threatening illnesses, accompanied by excessive action or, conversely, avoidant health behaviors (repeated visits to specialists or avoidance of consultations). Symptoms cause marked distress or significant impairment in personal, family, social, academic, occupational, or other important areas of functioning.

In the clinical case presented, there were no significant depression and anxiety and domestic or social maladjustment. No fixation on the fact of any serious illness and its potential consequences was observed.

ICD-10 deliberately causing or feigning physical or psychological symptoms or disabilities (faking a disorder) (F68.1) involves the periodic or continuous feigning of symptoms in the absence of an established somatic or mental disorder, illness, or impaired ability to work. The motivation for this type of behavior is vague and internal and involves assuming the role of a patient.

ICD-11 describes "fictitious self-disorder" (6D50) as feigning, falsifying, or inducing somatic, psychological, or behavioral symptoms in oneself. This can also involve exacerbating symptoms of an existing illness, supported by evidence of falsification, and motivated by a variety of goals, not just apparent

extrinsic rewards. The individual must seek medical attention or otherwise declare the presence of an illness, injury, or impairment.

Patient D deliberately feigned, exacerbated, and provoked somatic symptoms. The patient was prone to health complaints throughout her childhood, as she was raised in a medical environment. Over time, she began to exaggerate her mild myopia and accommodative spasm, secretly abuse atropine sulfate instillations, and demand more and more tests and treatments, up to retrobulbar dexamethasone injections.

With frequent changes in consulting specialists (gastroenterologists, cardiologists, neurologists, endocrinologists, ophthalmologists, and psychiatrists), the complaints remained unspecific, incomplete, and inconsistent and tended to resolve spontaneously. Despite the severity of the reported symptoms, they did not result in impaired functioning or depressive–anxiety spectrum disorders. Following the restoration of her vision, amidst assurances from others of a favorable prognosis, the patient started seeking medical attention again and continued to exacerbate psychological examination. Subsequently, she claimed that she had not told the psychiatrist everything and that repeated consultations were necessary.

Notably, the presence of common risk factors for this disorder—female sex, young age, connection with the medical profession, and presence of personality disorder (separate traits of schizoid and hysterical and emotionally unstable types)—in the differential diagnostic search leads to diagnosis of Munchausen's syndrome as the most reasonable result.

The difficulties encountered in diagnosing the condition of patient D by different specialists, which are of general importance in such cases, is noteworthy. The assumption of aggravation of symptoms appeared only two years after the first complaints of significant deterioration of vision. The simultaneous presence of organic causes of visual impairment (mild myopia, paresis of accommodation, and mild perineural edema of the optic nerve according to MRI data) allowed to assume the objective nature of the presented symptoms for a long time.

Consultations at the early stage of visual impairment by psychiatrists, who had no information about the potentially deliberate provocation of symptoms, led to the conclusion that no mental illness or that a somatoform disorder was present, with the prescription of mild anxiolytics. However, reports of complete loss of vision with good social and motor functioning, covert refusal of antihypertensive medication, requests for increasingly invasive medical interventions, and the discovery of symptom provocation led physicians to suspect simulative behavior on the part of the patient.

Recognizing the descriptive nature of the ICD-10 and ICD-11 diagnostic criteria, as well as the need to carefully evaluate all the nuances of individual clinical cases to establish the most appropriate diagnosis, the following table (Table3) of simplified criteria for assessing somatic symptoms in the absence of objective confirmation of somatic disease seems possible.

CONCLUSIONS

Whether somatization should be considered a purely psychiatric disorder in the form of a learned pattern of behavior or it should be viewed as a syndrome of multiple unexplained somatic symptoms that complicate the patient's overall health remains controversial.

The timely and accurate diagnosis of a factitious disorder is a major challenge and requires coordination of an interdisciplinary team of specialists. The factors that make such diagnosis difficult are the culture of trusting patient's complaints, principle of voluntary medical care, patient's right to medical confidentiality, lack of therapeutic cooperation, and the patient's avoidance of diagnostic procedures when imitation is detected. In addition, the need for common medical databases, medical record keeping, continuity of medical care within a specialty, and interdisciplinary interactions must be recognized.

In case of suspicion of subjective character of visual impairment, besides exclusion of organic pathology, objective confirmation of the patient's nonphysiologic character of subjective symptoms during ophthalmologic examination is necessary.

Organizational and methodological measures for early detection of patients with simulated disorders, creation of separate positions of specialists in simulated disorders, application of special ophthalmological tests based on patients' ignorance of the physiological structure of the visual apparatus, and allowing

Table 3. Differential diagnosis in the presence of nonorganic somatic symptoms

Nonorganic somatic symptoms	
Unconsciously reproduced symptoms	Deliberately reproduced symptoms
Dissociative disorders (F44): – Unrecognized pattern of symptom onset – Decreased functioning – Motivation for decline in functioning and resulting consequences – Often associated with a stressful event	*Munchausen's syndrome (F68.1)*: – Deliberate imitation of symptoms to the point of direct self-harm – Often without impaired functioning – Unclear intrinsic motivation – Often personality disorder
Somatized disorder (F.45.0): – Multiple varying sensations – A desire for relief from symptoms – Often depression and anxiety – Often decreased functioning	*Simulation (Z76.5)*: – External benefit motivation
Hypochondriac disorder (F45.2): – Fear of having a dangerous disease – A desire to be identified as having such a disease – Often depression and anxiety – Often decreased functioning	—

to assume the nonorganic nature of the disorder, which are standard in many foreign ophthalmological clinics, have not yet become widespread in Russian ophthalmological practice.

Thus, increasing physicians' awareness and attention to Munchausen's syndrome should be emphasized to ensure appropriate management of these patients and prevent them from potentially harmful medical interventions.

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