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Factitious Lymphedema of the Hand*

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ABSTRACT: **Twenty-two patients with factitious lymphedema of the hand were reviewed. Thirteen were female, with a median age of sixteen years at the onset of symptoms. Of the nine males, the median age at onset of symptoms was thirty-two years. The dominant hand was affected more frequently than the non-dominant hand. Edema was usually caused by a tourniquet, irritation of the skin, or blows to the back of the hand. Neurosis, psychosis, or suicidal tendency was diagnosed in twelve of these patients. Characteristically, the edema was not particularly painful; it frequently ended proximally in a circumferential discolored constriction ring; and it occasionally displayed characteristic lymphangiographic findings of normal or dilated lymphatic channels with increased collateral circulation and multiple blowouts. Although ten of the patients received Workmen's Compensation benefits, the course and psychiatric diagnosis indicated that malingering for secondary financial gain was not a primary goal. Hospitalization is usually required to confirm the diagnosis. Psychotherapy is indicated once the diagnosis is made.**

Recurrent or chronic edema of the hand following a relatively minor injury may be self-induced. Tourniquets, blows to the hand, or repeated irritation of the skin may cause such factitious lymphedema. Often the etiology of the swelling is not suspected despite extensive diagnostic and therapeutic procedures. Although the underlying pathopsychology of factitious illness is variable, certain clinical patterns have become evident in patients with factitious lymphedema of the hand.

Clinical Material

Twenty-two proved or presumed cases of factitious lymphedema of the hand were reviewed (Table I). In each case, either the patient admitted causing the edema or was observed intentionally injuring the limb, or the history, physical findings, and ultimate course of the illness were such that a factitious etiology was strongly presumed.

Thirteen of the patients were female. At the onset of symptoms, the youngest of these patients was thirteen years old and the oldest was forty-two. The median age was sixteen. Only two of the women were receiving Workmen's Compensation benefits and both of them were over thirty years old (Table I). Of the nine men reviewed, the youngest was twenty-four years old and the oldest was fifty-three. The median age was thirty-two.

All the male patients received Workmen's Compensation or veteran's benefits.

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TABLE I

FACTITIOUS LYMPHEDEMA OF THE HAND: REVIEW OF TWENTY-TWO CASES

	Female	Male	Total
No. of patients	13	9	22
Age at onset	13-42 years	24-53 years	
Median age at onset	16 years	32 years	24 years
No. receiving compensation benefits	2 (both over 30)	9	11
Hand primarily affected			
Dominant	8	6	14
Non-dominant	5	1	6
Bilateral or dominance not noted	0	2	2

All of the female patients were either students, clerical workers, or unemployed. They all appeared to be of average or above-average intelligence. Several attended college and professional schools. All of the male patients were blue-collar workers having jobs as laborers, porters, or machinists. The male patients were of normal or low normal intelligence. None had attended college.

In fourteen patients, the dominant hand was affected. Edema later developed in the opposite limb of one of these patients. In six patients, only the non-dominant hand was affected. In one patient both hands were equally affected and in one the dominant side was not noted.

In the patients studied, factitious illness had been present for three months to twenty-eight years. Usually, the edema was intermittent. It tended to recur during times of emotional stress. With several patients receiving Workmen's Compensation benefits, edema returned when they were advised to return to work. In almost all patients who were hospitalized, edema subsided during the first one or two days after admission.

In two patients, edema was accompanied by a glove anesthesia. Discoloration of the dorsum of the hand, circumferential striae or skin indentation proximal to the edema, and intrinsic-muscle contracture were frequently noted in the involved limb. In the male patients, physical signs and symptoms were principally confined to the affected limb. In the female patients, however, symptoms were more diffuse. Several had a history of gynecological complaints (leading to hysterectomy in one woman of nineteen), cystitis, conjunctivitis, and musculoskeletal problems involving the other limbs. One patient had multiple abscesses of both breasts requiring bilateral simple mastectomy.

The apparent inciting cause of edema was variable. In eleven patients, edema followed a blow to the hand; in five, a fall; in two, a laceration; in two, edema followed surgery; in one, it followed the removal of a splinter from the hand; and one patient offered no history of initiating trauma.

Seventeen of the patients had previously been diagnosed as having non-factitious illness as the cause of the edema. Six patients had been treated for some form of sympathetic dystrophy such as causalgia, Sudeck's atrophy, or Sécretan's disease. Three had undergone sympathectomy. One of these patients had had bilateral cervical and lumbar sympathectomy. Other diagnoses included juvenile rheumatoid arthritis, "dorsal blow contusions syndrome," peritendineal fibrosis, and ulceration. Ten patients had surgical exploration of the dorsum of the hand. One underwent amputation of several fingers. One required below-the-elbow amputation.

Seventeen of the patients were seen by a psychiatrist. Five were diagnosed as showing evidence of psychic overlay, large emotional overlay, or psychopathology. Four were diagnosed as having conversion hysteria and eight were said to be "smouldering" psychotic, psychotic, acute schizophrenic, or suicidal.

The apparent cause of factitious edema was the application of a tourniquet to the limb in twelve patients. Most frequently the tourniquet consisted of a tightly wound article of clothing such as a kerchief, or an elastic bandage or rubber band. Seven patients repeatedly contused the dorsum of the hand. One girl admitted striking the hand against desks, chairs, tables, and lockers in order to produce the swelling. Three patients repeatedly irritated the hand by scratching it or inserting small foreign bodies beneath the skin.

Four of the female and one of the male patients appeared to be "cured" of the lymphedema at the time of writing. Two of these female patients underwent prolonged psychotherapy. Of the other three patients, none were examined more than one year after the apparent cure.

The Differential Diagnosis of Upper-Limb Lymphedema

Many conditions may cause edema of the limb. With lymphatic aplasia or hypoplasia [6] or Milroy's disease, the lower limbs are more severely involved and edema typically is noted in childhood [9,10]. Lymphedema praecox develops in adolescence and limb involvement is usually symmetrical [3]. Lymphangiography in these cases will reveal the aplasia or hypoplasia of the lymph channels.

Tumor, surgery, irradiation, and filariasis may cause lymphatic obstruction. In these patients, the history and physical findings will often be diagnostic [15,16]. Lymphangiography will show chronic obstruction pattern at the site of lymph stasis, and dilated channels with occasional blow-outs more distally.

With factitious lymphedema caused by intermittent application of a tourniquet, a so-called broken windowpane pattern of collateral lymphatic circulation distal to the site of tourniquet obstruction is seen. Ruptured lymph channels due to recurrent lymph stasis and direct constriction may also be seen. The size and distribution of the lymphatics is normal, however. There is no abnormality of the lymph nodes.

Venous obstruction in the region of the thoracic outlet or within the arm may cause upper-limb edema. In such patients the veins will be distended, and if venography is performed with the limb abducted and extended, venous blockage should become apparent. With factitious lymphedema, venography, typically, is normal.

Sympathetic dystrophy or any of its variants may cause redness, swelling, and pain about the hand. Typically, in sympathetic dystrophy, however, the predominant symptom is severe pain, which is usually burning in nature and is accentuated by touching or moving the hand. Many of the patients with factitious lymphedema do complain of severe pain. Yet pain is rarely the chief complaint. Usually the pain is not described as burning, nor is it associated with hypersensitivity of the skin. Excessive perspiration and extreme bone atrophy, so frequently seen with sympathetic dystrophy, are rarely found with factitious lymphedema. The patient with factitious lymphedema often will discuss the severity of his pain in a most casual manner. His affect is quite unlike that of the anxious and distraught patient with causalgia who cradles his hand while complaining of the pain. Frequently, a cervical sympathetic block may relieve the patient's complaint of pain with factitious lymphedema, but the results are always transitory.

Sécretan's disease is a rather poorly defined entity described as traumatic hyperplasia and firm edema of the dorsum of the metacarpals [8,13]. Surely, trauma can result in an organized hematoma about the extensor tendons at the dorsum of the hand. It would seem unlikely, however, that such a fibrinoid hemorrhagic clot could persist for several weeks or months without repeated trauma, in the absence of a bleeding or clotting-factor deficiency. Perhaps factitious lymphedema may have been a feature in some of Sécretan's cases.

Systemic abnormalities such as collagen disease, hypoproteinemia, and cardiac, renal, or hepatic disease will rarely cause unilateral edema of the upper limb. Appropriate laboratory studies should be adequate to rule out the unlikely exception.

Plan of Management in Cases of Suspected Factitious Lymphedema

Factitious lymphedema is suspected in any patient with chronic or recurrent unilateral upper-limb lymphedema which is unassociated with any apparent systemic or local obstructive disease. If transverse striae or sulci are seen proximal to the edema, the diagnosis becomes most likely. Hospital admission is recommended for all suspected cases. The patient is not told of the presumptive diagnosis at the time hospital admission is being arranged.

On admission to the hospital, roentgenograms of the chest, shoulder, and upper limb are studied for evidence of tumor, cervical ribs, or potentially obstructive osteophytes. Laboratory studies, including prothrombin time, total protein albumin, globulin, and bleeding and coagulation times are determined. Venography and lymphangiography are performed. The patient is instructed to keep the limb elevated on two pillows but no measures are taken to enforce this regime. Often the edema will subside during the first one or two days of hospitalization, possibly because the hospital routine does not ensure privacy. Within a few days, however, edema will often recur. Surprising a patient at early morning rounds or in the middle of the night has on three occasions revealed a tourniquet tightly wound about the arm. Whether or not the patient has been observed injuring the limb, psychiatric interview is then recommended. Although psychiatric consultation is often resisted by the patient (''I don't need the shrink — I want you to fix my arm''), the patient usually can be convinced of its value.

During the last two days of hospitalization an extremely thick but *non-compressive* cotton bandage is applied from the shoulder to the finger tips. Elevation is not enforced. If the patient is unable to gain access to the limb, the edema will often subside; the diagnosis of factitious lymphedema may then be presumed.

Heavy cotton dressings are applied to the limb when the patient is discharged in order to prevent further self-injury. Psychotherapy is urged.

Case Reports

CASE 1. A forty-two-year-old unmarried secretary struck the dorsum of the left (non-dominant) long finger on her typewriter while at work. Within a few days of the injury, relatively painless but moderately severe swelling about the hand and the distal part of the forearm developed. The swelling was diagnosed as tenosynovitis, infection, and Sudeck's atrophy. Oral medications, stellate ganglion blocks, and physical therapy were administered without improvement. Over the ensuing years, edema of enormous proportions persisted and extended progressively more proximally. The edema always was limited by a circumferential reddened excoriated sulcus at progressively higher levels about the forearm (Fig. 1). The patient was admitted to several hospitals, and each time the edema would subside within one or two days of hospitalization, often before treatment had been rendered. On one occasion she was seen to apply a tightly wound kerchief about the upper part of the forearm. She was referred for psychiatric consultation, which she refused. She continued to receive total disability payments sixteen years after the original injury.

CASE 2. A sixteen-year-old female high-school student had severe edema of the left (non-dominant) hand and wrist several weeks after having received intravenous therapy following tonsillectomy. The edema ended circumferentially about the wrist in a thin, discolored bruise. She had been diagnosed as having synovitis. On admission to the hospital for evaluation she appeared cooperative and pleasant. She submitted willingly to all tests and examinations.

The patient stated that she was an ''A+'' student and desired to become a physician. Because of this ambition, she stated, she was under great pressure to obtain satisfactory school grades.

All swelling subsided completely within the first few days of hospitalization. On the third day, however, the edema suddenly recurred. She was noted at six o'clock the following morning to have a tightly wound elastic bandage about her wrist at the site of the circumferential bruise marks (Fig. 2). On psychiatric consultation, she was diagnosed as having depression with underlying psychopathology. She refused psychotherapy. At the time of writing she continued to have intermittent swelling with skin ulceration, one and one-half years after the onset of the edema.

CASE 3. An intelligent thirteen-year-old girl was struck on the dorsum of the right (dominant) hand with a baseball bat while at summer camp. The incident occurred shortly after the birth of her half-brother. The patient had been living with her divorced mother and her stepfather.

In the days following the injury, the hand became extremely swollen and the patient was seen by local doctors, who recommended that she return home at once. The edema became more severe and extended to the midforearm. A biopsy was performed at the dorsum of the hand which was said to reveal fibrosis about the tendons. Swelling persisted intermittently for several months. There was relatively little pain. Six months after its onset, the swelling resolved spontaneously and completely.

The following summer, approximately one year from the time of the initial injury, edema recurred, with no history of additional trauma. The

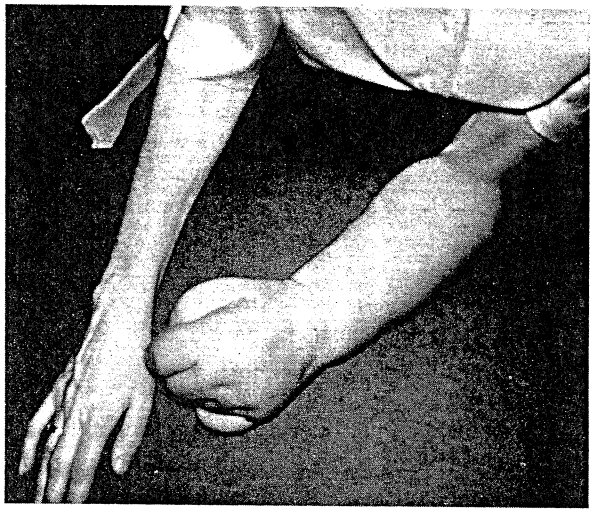

FIG. 1

Case 1. This forty-eight-year-old female secretary had had intermittent edema of the left upper limb since striking the left long finger on her typewriter carriage six years previously. Note the abrupt termination of the edema in a circumferential sulcus below the elbow. The patient was seen applying a handkerchief tightly about the forearm while she was hospitalized.

edema ended abruptly in a circumferential ring of red skin below the elbow. Many medical consultations were sought and the patient was admitted to a minimum of seven hospitals over a period of several months. The diagnoses included juvenile rheumatoid arthritis, synovial cysts, lymphedema praecox, Sécretan's disease, and sympathetic dystrophy. All laboratory tests and roentgenograms were within normal limits. She was forced to stop attending school because of her illness.

Intermittent edema persisted until two years after the onset of her complaints, at which time a right cervical sympathectomy was performed. The lymphedema cleared completely after surgery. Some months later the right leg became edematous. A right lumbar sympathectomy was performed and again the edema subsided. Within a year lymphedema of the left upper limb developed. A left cervical and then a left lumbar sympathectomy were performed.

One year later lymphedema again recurred in the right upper limb. The right cervical sympathetic chain was again explored and excised. Shortly thereafter the patient became overtly psychotic and was admitted to a mental hospital after attempting suicide by cutting both wrists. Under psychotherapy she explained that for the preceding years she had applied tourniquets to her limbs in order to cause the edema. There were no further

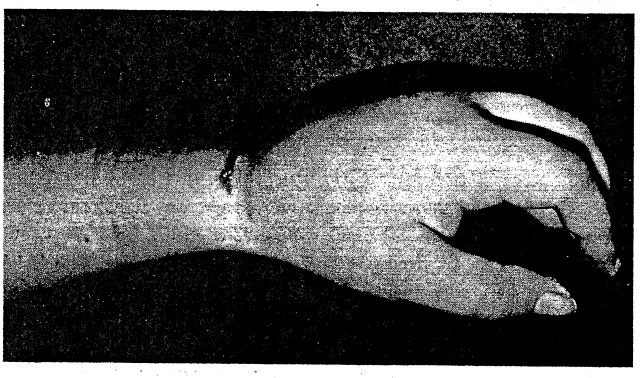

FIG. 2

Case 2. This sixteen-year-old girl had intermittent swelling of the non-dominant left hand for six months following intravenous therapy after tonsillectomy. After four days of hospitalization with elevation and occlusive dressings, the edema had lessened and a circumferential rim about the wrist had flattened. One day later she was observed at early morning rounds with an elastic bandage wrapped tightly around her wrist. Both the ridging and the edema had recurred. This photograph was taken one hour after the self-applied tourniquet was removed.

reported incidents of lymphedema following prolonged psychotherapy.

CASE 4. A bright fourteen-year-old female student injured the right dominant hand when she struck the bumper of an automobile. There was immediate swelling of the dorsum of the hand and lower forearm. Swelling and redness persisted intermittently, with apparently spontaneous exacerbations and remissions, for several years. She was diagnosed as having a blood clot or cyst and on several occasions a hematoma was aspirated from the dorsum of the hand. Exploration of the dorsum of the hand revealed fibrous tissue.

Because of the apparent factitious nature of the edema and swelling, which continued for four years, she was finally referred for psychotherapy. She was diagnosed as being self-destructive and manic depressive. Under psychotherapy she reported that she repeatedly struck her hand against tables, doors, and chairs. While under psychotherapy she attempted suicide. Her treatment was not complete at the time of writing.

CASE 5. An apparently healthy fifteen-year-old girl had acute appendicitis which was treated by surgery. When she was eighteen an intestinal obstruction developed. Thereafter she had repeated and continual complaints which led to seven operations for intestinal adhesions, five for uterine dilatation and curettage, and two for abscesses of the breast requiring simple mastectomies.

When she was thirty-nine she injured the left ring finger when it was cut on a venetian blind. Although the wound healed without incident, swelling and contractures of both the ring and little fingers developed. She sustained another injury to the fingers one year later, when they were cut on a refrigerator door. Swelling became even more severe, and because of complaints of pain and obvious erythema the ring and little fingers were amputated one and one-half years after the original accident. One month later contracture of the long finger developed. There was swelling and redness about the dorsum of the hand and suspicion of "infection on the dorsum of the hand even though the patient is afebrile and white blood count is 6000." Two and one-half years after the original accident she sustained a third injury between the thumb and index finger. Because of exacerbation of swelling and pain she was operated on again and silastic capping of neuromatous nerve ends was performed. At about this time it was noted that the swelling about the hand extended "right up to the constricting rolled tape band she has wound around her wrist." She was seen in psychiatric consultation and diagnosed as having chronic schizophrenia, chronic depression, masochistic character disorder, and hyperindependent personality. Despite psychotherapy she continued to have intermittent redness and swelling about the remnants of her hand seven years after the initial hand injury.

CASE 6. An intelligent thirteen-year-old female student was operated on for removal of a ganglion from the dorsum of the right hand. The wound was slow to heal and there was persistent ecchymosis about the dorsum of the hand and wrist. Swelling developed first about the wrist and then more proximally about the forearm and arm. She was diagnosed as having a "bleeding tendency." The dorsum of the hand was explored and scar tissue found about the extensor tendons. She did well for three years, after which swelling and ecchymosis returned spontaneously. Exacerbations and remissions of the swelling were unrelated to activity. She was treated with sympathetic ganglion blocks with no effect. Arteriography was normal. She was admitted to several hospitals in the northeastern United States and in England. On one occasion, ten years after the original incident, she was discovered in the middle of the night with an elastic bandage tourniquet about the upper limb. There were ecchymotic transverse striae about the upper forearm and lower arm (Figs. 3-A and 3-B). The patient subsequently attempted suicide. She was treated with psychotherapy and at the time of writing was pursuing a successful professional career. She was apparently cured.

CASE 7. A thirty-two-year-old machinist of normal intelligence fell and struck his left (non-dominant) hand against the floor. Severe edema developed, extending to a circumferential sulcus in the mid-forearm. The edema persisted and was so severe one year after injury that amputation of the forearm was considered. Edema spontaneously subsided two years after its onset, at which time the patient sustained a back injury. This required laminectomy, following which he continued unemployed and received Workmen's Compensation benefits.

FIG. 3-A

FIG. 3-B

Fig. 3-A: Case 6. For ten years this twenty-three-year-old graduate student had been seen for recurrent edema and petechial hemorrhages about the right upper limb following ganglion removal. In this photograph the hand is to the bottom, the shoulder to the top. Note the transverse, circumferential bands of discoloration. Petechial hemorrhages are seen at the lower aspect of the forearm. The soft tissues above the elbow (top of the photograph) are narrowed.

Fig. 3-B: The patient was surprised in her hospital room after midnight by an alert staff member. The photograph reveals the manner in which the bandage was being used to provide a tourniquet effect. (Photographs courtesy of Mr. Noel Thompson, London, England.)

Lymphedema of the upper limb recurred seven years after the original incident. Swelling had become so severe, the patient stated, "that the skin often split open on the back of my hand." Swelling would disappear almost completely with the application of an occlusive dressing to the entire limb (Fig. 4-A). Circumferential ecchymotic linear bands were noted at the upper part of the forearm one year after the recurrent edema (eight years after the original episode). One year later he returned with circumferential ecchymotic bands at the upper aspect of the arm just distal to the axilla (Fig. 4-B). He had total anesthesia of the entire left upper limb and left anterior chest. He demanded amputation at the wrist. He was seen in psychiatric consultation and diagnosed as having conversion hysteria.

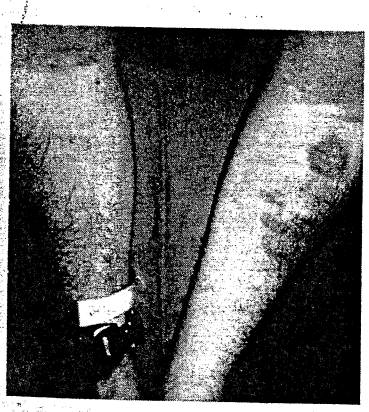

FIG. 4-A

FIG. 4-B

Case 7. This forty-year-old male machinist had severe swelling about the left upper limb after a fall eight years previously. At the time the edema was so marked that amputation of the forearm was considered. Swelling subsided spontaneously after two years. These photographs were taken in 1973, one year after the swelling had recurred. Transverse striae are noted at the upper part of the left forearm. The patient complained of severe edema which caused the skin to "split open." During hospitalization there was marked improvement despite the absence of any therapeutic measures.

Fig. 4-B: One year later the patient returned, demanding amputation at the wrist. There was swelling and edema with transverse striae at the upper arm. There was total numbness of the left upper limb including the shoulder and the left anterior thorax. He was referred for psychotherapy. He refused psychotherapy. His condition remained stormy at the time of writing.

CASE 8. A twenty-five-year-old unmarried, uneducated porter cut the dorsum of his right dominant hand with a piece of glass while at work. There was swelling, pain, and drainage about the wound. He sought medical care. Despite dressings and antibiotics, the wound continued to enlarge over the next several months. It deepened through the extensor tendons to the third metacarpophalangeal joint. Swelling about the dorsum of the hand became progressively more severe. The entire limb was placed in a mild compressive dressing extending from the axilla to the finger tips. Within several weeks the wound closed completely and the edema had subsided.

One month later he was sent back to work. Within two weeks the previous wound reopened, edema recurred, and the patient was again referred for medical treatment. Wound cultures were repeatedly sterile. Due to the size of the defect, a local skin flap was applied. The wound closed and edema subsided within two weeks. The patient remained asymptomatic for several months until he was once again asked to return to work. The ulcer and swelling again reappeared.

He was referred for psychiatric treatment but refused. He was lost to follow-up after two years.

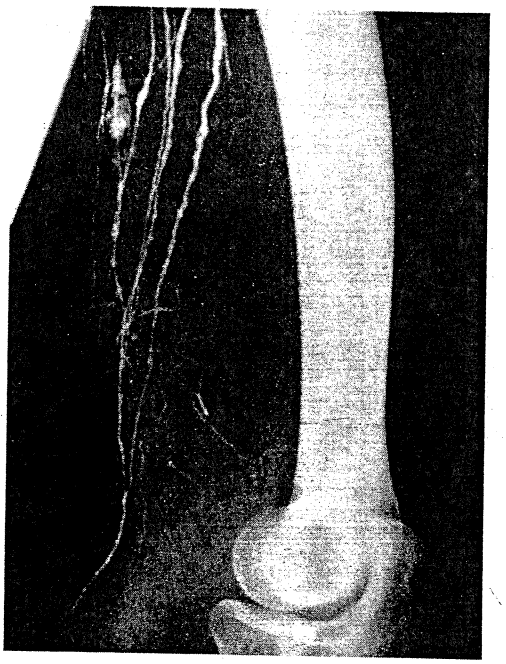

FIG. 5

Case 9. A lymphangiogram of the arm of a patient with factitious lymphedema is shown. This patient had been applying a tourniquet to the arm several centimeters above the elbow. There is neither decreased caliber nor decreased number of lymphatic channels in the limb. The lymphatic valves are visualized. The so-called broken windowpane effect of increased collateral circulation in the region where the tourniquet had been applied and just distally, and several "blowout" areas are seen. If lymph stasis is chronic and severe, lymph channels may be dilated.

CASE 9. A forty-two-year-old male laborer of apparently normal intelligence struck the dorsum of the right dominant hand at work. There was extensive swelling about the hand and forearm. The swelling extended to a circumferential sulcus several centimeters proximal to the elbow. He complained of severe pain and some numbness. He was diagnosed as having sympathetic dystrophy, for which a cervical sympathectomy was performed. There was no improvement following sympathectomy.

Because of continued swelling the patient was admitted to the hospital two years after the onset of symptoms. He appeared hostile towards medical personnel and spent his hours in the hospital writing a religious poem which had already extended over 400 pages. He reported to the psychiatrist of talks he had "with the Lord."

Lymphangiography revealed ruptured lymph channels and a broken windowpane pattern of collateral lymphatic circulation distal to the site of circumferential skin ridges several centimeters proximal to the elbow (Fig.

5). The size and distribution of the lymphatics were normal. No abnormality of the lymph nodes was noted.

The edema subsided completely during hospitalization. Although there was a full and painless range of motion of all joints about the affected upper limb, with no evidence of atrophy in this well-muscled man, he was unable to perform tasks at occupational therapy because of "severe pain." He was seen by a psychiatrist and diagnosed as a "smouldering psychotic." He refused psychotherapy.

Discussion

Psychopathology should be suspected as the basis of virtually all cases of factitious lymphedema [2,7,11,14]. Whether the patient has a psychic overlay, or is a neurotic, hysteric, psychotic, or schizophrenic, can be determined only by a psychiatrist. Even in this small series, several of the patients who appeared most pleasant, most cooperative, and most intelligent were proved to be psychotic. One attempted suicide. For the surgeon to confront, scold, or accuse the patient with factitious disease would appear to be most dangerous for the patient and for the doctor. It would serve no purpose but to increase the hostility of the patient and might complicate adequate psychotherapy.

Malingering is feigning illness for secondary gain. Patients with factitious lymphedema are not *feigning* illness; they are *causing* illness. The material gain some may obtain in the form of compensation awards would be considered by most as relatively trivial for the pain and inconvenience they produce and tolerate. Surgery — even amputation — is rarely refused and may even be sought. These patients are not malingerers.

The term Munchausen's syndrome has been used to describe the patient who seeks medical treatment for factitious illness and invents fanciful and elaborate historical details to confound and intrigue medical personnel [1,4,5,11]. The motives are quite variable and have included a desire to impugn or challenge authority (to fool the omniscient "father-image" doctor) and to gain attention. The term Munchausen's syndrome refers to the eighteenth-century Thuringian nobleman, Baron Hieronymous Karl Friedrich von Munchhausen*, whose invented and dramatic whimsical tales won him legendary fame [12].

* Virtually all medical references misspell Munchhausen as Munchausen. This probably dates to Raspe's misspelling of the name in 1785 with but one "h." Thus, the medical syndrome is now spelled with one "h" although the Baron spelled it with two.

The term Munchausen's syndrome has occasionally been used to refer to any factitious illness. Yet, it would appear ill advised to apply this term to most patients with factitious lymphedema. These patients do not invent long fanciful stories regarding their illnesses. On the contrary, the details they provide regarding the medications and treatment they have received at other hospitals and from other doctors is usually explicit and accurate. Factitious lymphedema is not a syndrome, but rather represents a wide spectrum of psychic disorders.

Conclusions

1. Factitious etiology should be suspected in any patient with recurrent or chronic unilateral upper-limb lymphedema without apparent lymphatic or venous obstruction.

2. Factitous etiology may be presumed in any patient with recurrent or chronic unilateral upper-limb lymphedema which is limited proximally by a well demarcated ring or sulcus of circumferential discoloration.

3. Factitious lymphedema of the hand was observed in two distinct groups: (a) the intelligent or well educated adolescent girl or young woman undergoing social or emotional stress which she has difficulty handling, and (b) the male blue-collar worker who is dissatisfied with his job, or his role or station in life.

4. The diagnosis of factitious lymphedema of the hand is best made by thorough in-patient evaluation and observation, along with appropriate laboratory, roentgenographic, and psychiatric studies.

5. The patient with factitious lymphedema of the hand is often suffering from a serious emotional disorder and is unlikely to be a malingerer. Once the diagnosis of factitious lymphedema is made the patient should be referred for psychiatric care. Personal confrontation between the surgeon and the patient should be avoided.

6. Hand surgery does not cure factitious lymphedema of the hand. Exploratory surgery in suspected cases will offer little helpful information in establishing a diagnosis. The surgeon should not attempt to cure factitious lymphedema of the hand once the diagnosis has been made.

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