graphic warnings on charcoal briquet packaging and other hazardous heating material have been suggested (6). Wrenn and Conners (5) feel that emergency physicians should be cognizant of how to inform the media and disseminate information regarding indoor heating devices (5). Whether such preventative measures are, indeed, the logical purview of the emergency physician or are better left to public health officials is a matter for discussion, but the hazards of CO poisoning in the context of inclement winter weather seem destined to continue.

George Sternbach, MD, FACEP
Emergency Medicine Service
Stanford University Hospital
Stanford, California
Joseph Varon, MD, FACP, FCCP
Department of Anesthesiology & Critical Care
The University of Texas
M. D. Anderson Cancer Center
Houston, Texas

PII S0736-4679(97)00087-5

REFERENCES

1. Unintentional deaths from carbon monoxide poisoning—Michigan, 1987–1989. MMWR. 1992;41:881–9.
2. Cobb N, Etzel RA. Unintentional carbon monoxide-related deaths in the United States, 1979 though 1988. JAMA. 1991;266:659–63.
3. Gasman JD, Varon J, Gardner JP. Revenge of the barbecue grill—carbon monoxide poisoning. West J Med. 1990;153:656–7.
4. Houck PM, Hampson NB. Epidemic carbon monoxide poisoning following a winter storm. J Emerg Med. 1997;15:000–000.
5. Wrenn K, Conners GP. Carbon monoxide poisoning during ice storms: A tale of two cities. J Emerg Med. 1997;15:000–000.
6. Silvers SM, Hampson NB. Carbon monoxide poisoning among recreational boaters. JAMA. 1995;274:1614–6.
7. Hampson NB, Norkool DM. Carbon monoxide poisoning in children riding in the back of pickup trucks. JAMA. 1992;267:538–40.
8. Hampson NB, Kramer CC, Dunford RG, Norkool DM. Carbon monoxide poisoning from indoor burning of charcoal briquets. JAMA. 1994;271:52–3.
9. Fisher J, Rubin KP. Occult carbon monoxide poisoning. Arch Int Med. 1982;142:1270–1.
10. Grace TW, Platt FW. Subacute carbon monoxide poisoning. Another great imitator. JAMA. 1981;246:1698–1700.
11. Sternbach G, Varon J. Carbon monoxide poisoning. West J Med. 1991;154:737

☐ EXTORTION IN THE EMERGENCY DEPARTMENT

In this issue of the *Journal of Emergency Medicine,* Sousa et al. (1) have an excellent and thought-provoking article about "Extortion in the Emergency Department." Personality disorders that present to the emergency department (ED) will demonstrate a variety of initial complaints and subsequent follow-up. The presentation of a borderline personality may be indistinguishable from an antisocial personality.

Malingering is the conscious simulation of disease for financial or legal gain. History of antisocial behavior and drug addiction is common. Antisocial behavior usually starts before the age of 15. This behavior would include a history of truancy, expulsion from school, delinquency, persistent lying, fighting, confrontation with the law, promiscuity, and running away from home.

Factitious disorders are a form of somatization that involves apparent deception, simulating illness, and imposture. This deception may be distinguished from other forms of lying in that patients with factitious disorders may suffer from underlying disturbances in the sense of reality and in reality testing. These features may be associated with a poorly consolidated sense of self and with difficulty regarding emotional experience as real. Factitious behavior may serve to stabilize the sense of self by concretizing and legitimizing the subjective experience of distress and by evoking responsiveness of a caregiver in a relatively safe, structured context. Such patients do poorly in psychotherapy and do best with an understanding primary care provider. Many authorities suggest that patients who behave factitiously are either undifferentiated schizophrenics or borderline personalities (2).

Unfortunately, there is insufficient psychosocial information on the patient mentioned in this paper. Understandably, such information is not necessary for a 12-cm arm laceration. Why does this patient force the physicians to do an X-ray scan of the arm if she is willfully planning on some future economic gain? Malingering is usually associated with an antisocial personality, and these patients are experts at manipulating their environment. This patient and her family's behavioral activity suggest characteristics of a borderline personality. The patient refuses an IM pain shot at the initial ED visit but later tolerates putting metal into her wound. She presents initially as a "muddy, unkempt woman appearing older than her stated age." Multiple old scars were noted on all extremities. One would wonder about the nature of her previous injuries. This patient does return for two follow-up visits and then things get "crazy."

She is 36 yr old and still living with her family of origin, which is reminiscent of the difficulty the borderline patients have in separating from their original families and developing a sense of autonomy. As a rule, antisocial malingerers would have asked for a lot more than $6000 for damages and hardship. This kind of