Clinical vignette: Trust but verify: When believing the patient leads the doctor astray

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### Case Presentation

**ID**
- 27-year-old woman with reported sickle-cell disease admitted for sickle-cell crisis

**History of Present Illness**
- Chest pain 45 minutes into cross-country flight
- Chest pain sharp, 7/10 in intensity, constant, substernal, and non-radiating
- Episode described as similar to her sickle-cell pain
- Chest pain not relieved with acetaminophen
- Plane diverted to airport
- Patient brought to hospital

**Past Medical History**
- Sickle-cell disease, requiring morphine PCA in past
- Protein C deficiency
- Pulmonary embolism (PE) on chronic anticoagulation
- Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia 1 month ago, first treated with vancomycin and later with daptomycin with port placed

**Outpatient Medications**
- Hydroxyurea
- Warfarin
- Daptomycin

**Emergency Department Events**
- Admitted by float resident overnight
- Morphine PCA started
- Reported outpatient medications restarted including hydroxyurea, daptomycin, and warfarin
- Care transferred to the hospitalist service

### Hospital Course

**Trust but verify!**
- Patient-identified hematologist said his testing failed to show sickle-cell trait or disease
- Hemoglobin fairly high for sickle-cell crisis
- Normal peripheral smear without sickle cells
- Negative sickle cell screen (solubility testing)
- Normal hemoglobin electrophoresis
- Calls and record requests to outside hospitals and pharmacies identified by patient were unsuccessful

**Patient Encounter**
- Patient confronted with inability to corroborate reported medical history and laboratory inconsistencies
- Patient became tearful
- She said “I know what I have.”
- Threatened to leave immediately
- Provided staff a different name and birthdate

**Disposition**
- Diagnosis of bacteremia one month prior was confirmed, but the organism was methicillin-sensitive (MSSA), not MRSA
- Given discrepancies in reported medical history, antibiotics and analgesics were discontinued
- Patient discharged from hospital
- Patient has had no further known encounters in our medical system
- No outside physicians or healthcare systems notified

### Discussion

**Differential Diagnosis**
- True medical or psychiatric disease
- Factitious disorder
- Desire to “play the sick role”
- Malingering
- Desire for external gain, conscious somatoform disorder (including hypochondriasis, conversion disorder)
- Delusional disorder

**Discharge Diagnosis**
- Factitious disorder

**Epidemiology**
- Female predominance
- Often linked to healthcare or “caring” profession
- Often stable social situation
- Comorbid psychiatric diagnoses
- Münchausen syndrome with male predominance, wandering (peregrination)

**Treatment**
- Confrontation
- Frequent visits
- Goal to reduce iatrogenic harm and encourage more adaptive behaviors
- Prognosis ultimately poor

**Conclusions**
- Physicians are taught to believe a patient’s story, but this case highlights the importance of verification in confirming details in order to exclude factitious disorder or malingering.
- The differential diagnosis of simulated illnesses includes factitious disorder, somatoform disorder, delusional disorder, and malingering.

### References