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

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**Case Presentation**

<table>
<thead>
<tr>
<th>ID</th>
<th>27-year-old woman with reported sickle-cell disease admitted for sickle-cell crisis</th>
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**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**

<table>
<thead>
<tr>
<th>Trust but verify!</th>
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<tbody>
<tr>
<td>patient-identified hematologist said his testing failed to show sickle-cell trait or disease</td>
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<td>hemoglobin fairly high for sickle-cell crisis</td>
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<tr>
<td>normal peripheral smear without sickle cells</td>
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<tr>
<td>negative sickle cell smear (solubility testing)</td>
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<td>normal hemoglobin electrophoresis</td>
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<td>calls and record requests to outside hospitals and pharmacies identified by patient were unsuccessful</td>
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**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**

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<tr>
<th>Differential Diagnosis</th>
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<td>true medical or psychiatric disease</td>
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<tr>
<td>factitious disorder desire to “play the sick role”</td>
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<tr>
<td>malingering desire for external gain, conscious</td>
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<tr>
<td>somatoform disorder (including hypochondriasis, conversion disorder)</td>
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<tr>
<td>delusional disorder</td>
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**Discharge diagnosis**
- Factitious disorder

**Epidemiology**
- female predominance
- often link 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**