Smith et al., Intern Med 2013, S12
DOI: 10.4172/2165-8048.S12-001

Internal Medicine: Open Access
ISSN: 2165-8048

Case Report Open Access

Factitious Hemoptysis after Right Lower Lobectomy

Joseph P Smith[2,3], Karina A Serban[1-3] and Gabriel T Bosslet[1-3]*

[1]*Division of Pulmonary, Allergy, Critical Care, and Occupational Medicine, Indianapolis, USA*
[2]*Department of Internal Medicine, Indianapolis, USA*
[3]*Indiana University School of Medicine, Indianapolis, USA*

Abstract

Hemoptysis is usually a sign of a serious condition (e.g. infectious, malignant, or systemic disorder) and requires an array of semi-invasive and/or invasive procedures to make a diagnosis. However, sometimes a less serious condition – factitious disorder – should be considered in the differential diagnosis because of the potentially dangerous consequences of repeated workups. Our case presents a 30-year-old African American female who presented with a complaint of fifteen hours of acute hemoptysis. We present the path to our discovery of the patient's history of Munchausen's syndrome and this episode of factitious hemoptysis such that our physician colleagues may keep differential diagnosis lists wide and protect patients with factitious disorder and Munchausen's syndrome from unnecessary risk inherent to the diagnostic and therapeutic procedures they undergo.

Introduction

Munchausen Syndrome is a psychiatric disorder in which a patient feigns physical or psychiatric symptoms to play the sick role [1-3]. The patient is aware of the method used to fake symptoms, but the motivation is unconscious [2]. Unlike malingering, a secondary gain does not exist [1-3]. This illness can be life-threatening due to the inherent risks of the diagnostic and therapeutic procedures used to rule out pathology in these patients.

Case Report

A 30-year-old African American woman presented to an academic hospital ED with a complaint of fifteen hours of sub massive hemoptysis. The patient reported a history of pulmonary AVMs (Arteriovenous Malformation) and was status-post right lower lobectomy after failed angiography and coil embolization five years prior in a neighboring state. Vital signs were as follows: Temperature 36.9 degrees Celsius, heart rate 129 beats per minute, respiratory rate 16, blood pressure 152/92 mmHg, and oxygen saturation 98 percent on room air. Hemoglobin was 12.1 grams per deciliter. The patient was in no acute distress, had a normal oral exam, and was without telangiectasias, purpura, rash, clubbing, or mucosal lesions. Lung examination revealed symmetric and clear breath sounds.

A Computed Tomography (CT) scan was unremarkable, with the exception of evidence of a previous right lower lobectomy. Bronchoscopy revealed no evidence of bleeding. She continued to report unwitnessed hemoptysis and would frequently have an emesis basin containing 100-300 cc of frank blood. Records for her previous hospitalizations at other hospitals out of state were requested, but there was no record of the patient. On the fourth hospital day, the patient was found leaning over a blood-filled basin wiping away bright red blood. A second bronchosopy and laryngoscopy at that time were unrevealing. Before a planned esophagogastroduodenoscopy, an anonymous caller notified the nurse that the patient had faked hemoptysis by placing blood from intravenous lines or menstruation in her mouth in the past.

The patient admitted to a prior history of Munchausen Syndrome. Among other episodes, she admitted to prior incidences of drawing blood from venous catheters and placing this blood in her mouth. Further, she stated that her repeated use of a syringe to draw blood from a central line had previously resulted in sepsis requiring mechanical ventilation. She would not admit to feigning the hemoptysis episode that resulted in a right lower lobectomy, but our suspicion is that this procedure was undertaken unnecessarily. Psychiatry was consulted declared her safe for discharge. An EMR search demonstrated three instances of her name with similar social security numbers and birth dates. All three patients had a reported history of pulmonary AVMs and factitious hemoptysis.

Discussion

Factitious hemoptysis is uncommon. Of the available case reports, only two describe patients with such extensive recurrent hospitalizations and such severe disease as to accept a highly invasive thoracotomy [4,5]. In table 1, we review previous case reports and the unnecessary invasive procedures, imaging, and treatments associated with these cases. Our patient's recurrent behavior, willingness to undergo invasive procedures, and travel to avoid detection are all common occurrences in Munchausen's syndrome. Her use of multiple aliases, social security numbers, and birth dates brings a new level of deception not seen in prior reports. This deception prevented our medical team, even with an electronic medical record through which unaffiliated hospitals share medical information, from matching this patient with other previous hospitalizations. Once suspected, a search of the electronic medical record revealed multiple aliases with different birth dates and social security numbers.

Detecting factitious hemoptysis is difficult. In retrospect, our patient had an unremarkable physical examination, unexpectedly stable vitals, and normal hemoglobin. Two bronchoscopic exams revealed no evidence of hemoptysis. During the entire hospitalization, her hemoptysis had never been witnessed – only the resulting blood was seen. Finally, the blood produced by the patient was noted to be unusually bright red for expectorated blood.

In order to do no harm, we as physicians must recognize that factitious hemoptysis exists and widen our differential to include this entity. A thorough history and physical examination, careful use of

***Corresponding author:** Gabriel T Bosslet, Indiana University School of Medicine, Division of Pulmonary, Allergy, Critical Care, and Occupational Medicine, 1481 W. 10th Street, 111P-IU, Indianapolis, USA, IN 46202; E-mail: gbosslet@iupui.edu

Received March 01, 2013; **Accepted** May 30, 2013; **Published** June 07, 2013

Citation: Smith JP, Serban KA, Bosslet GT (2013) Factitious Hemoptysis after Right Lower Lobectomy. Intern Med S12: 001. doi:10.4172/2165-8048.S12-001

	Age	Sex	Invasive procedures	Imaging	Treatment
Trew et al. 1970	27	F	Inferior vena cava ligation	CXRs, Pulmonary angiogram, V/Q scan, ABGs	Thrombolytic therapy x2, Antibiotics, Warfarin, Transfusion
Carroll et al. 1975	43	M		CXRs	Heparin, Warfarin, Narcotics
Roethe et al. 1981	21	F	Intubation/Mechanical ventilation x3, Tracheostomy, Bronchoscopy x2	CXRs, Bronchogram, Fluoroscopy x2	N/A
	34	F	Fiber optic bronchoscopy	CXRs, V/Q scan, Pulmonary angiogram	Anticonvulsants, Anticoagulants, Corticosteroids
	26	F	Fiber optic bronchoscopy x2, Laryngoscopy	CXRs, V/Q scan, Venous Duplex U/S, Bronchogram, Pulmonary angiogram	Warfarin, Heparin, 9 Transfusions
Bush et al. 1982	25	M	Fiber optic bronchoscopy x4, Left thoracotomy with lingula resection, 2nd thoracotomy with Left Upper Lobectomy, Laryngoscopy	CXRs, Bronchogram, Chest CT	Antibiotics
Feinsilver et al. 1983	30	F	Nasogastric tube, Fiber optic bronchoscopy x2	CXRs, Perfusion lung scan, Pulmonary angiogram x2, Venous Duplex U/S	Heparin, Warfarin, Isoniazid
Buddemeyer et al. 1983	30	M		CXRs, V/Q scan x2, Venous Duplex U/S, Venogram, Impedance plethysmography	Heparin
Mitchell et al. 1985	22	F	Fiber optic bronchoscopy x2, Intubation/Mechanical Ventilation	CXRs, Bronchography, Chest CT	Antibiotics, High dose IV corticosteroids, Transfusions
Duffy, 1992	33	M	Renal biopsy x3	CXRs, Renal U/S	High dose IV corticosteroids, plasmapheresis, Narcotics
Rusakow et al. 1993	19	F	Bronchial artery embolization, Central Venous Line placement	CXRs	Transfusions, Antibiotics, Corticosteroids
Baktari et al. 1994	36	M	Fiber optic bronchoscopy X16, Bronchial artery embolization	CXRs, 7 Chest CTs, 5 V/Q scans, Pulmonary angiogram x4, Bronchial arteriogram, Tc99 RBC tagged scan, Cardiac catheterization x3	Narcotics, Heparin, Antibiotics High dose IV corticosteroids
Ozden et al. 1999	17	F	Fiber optic bronchoscopy		Transfusions
Saed et al. 1999	22	F	Fiber optic bronchoscopy	CXRs, Chest CT, V/Q scan, Bronchial arteriography, Bronchogram	N/A
Gurkan et al. 2000	17	F	Upper endoscopy x3, Fiber optic bronchoscopy x3	CXRs, Chest CTs x2, CT angiogram, Tc99 tagged RBC scan	Transfusions
Bjornson, 2001	12	F	Upper endoscopy x2, Fiber optic bronchoscopy	CXRs	
Highland et al. 2002	25	F	Port-a-cath placement, Nasal endoscopy	CXRs, Sinus CT	Antibiotics, Narcotics
Santo Andrade et al. 2005	23	M	Fiber optic bronchoscopy >1, Upper endoscopy >1	CXRs, CT chest, V/Q scan	Isoniazid, Rifampin, Pyrazinamide
Kokturk et al. 2006	26	F	Fiber optic bronchoscopy x3, Laryngoscopy, Nasal endoscopy	CXRs, Chest CT, Sinus CT, Pulmonary angiogram, Tc99 tagged RBC scan	

CXR = Chest Radiograph; CT = Computed Tomography; V/Q scan = Ventilation Perfusion Scan; RBC = Red Blood Cell; ABG = Arterial blood gas; U/S = ultrasound; IV = intravenous

Table 1: Summary of Reports of Unnecessary Procedures, Imaging, and Treatment due to Factitious Hemoptysis.

invasive tests, and a review of prior medical records will assist in the diagnosis of factitious hemoptysis. When using the electronic medical record, searching using multiple forms of identification – the patient's name, social security number, date of birth, and medical record number – may result in a higher chance of discovering the patient's past history. With this knowledge, we can reduce unnecessary risks that these patients undertake.

References

1. American Psychiatric Association, Diagnostic criteria from DSM-IV-TR. 2000, Washington, D.C.: American Psychiatric Association. xii.
2. Andreasen NC, Black DW (2001) Introductory textbook of psychiatry. (3rdedn), Washington, DC: American Psychiatric. xix.
3. Ireland P, Sapira JD, Templeton B (1967) Munchausen's syndrome. Review and report of an additional case. Am J Med 43: 579-592.
4. Baktari JB, Tashkin DP, Small GW (1994) Factitious hemoptysis. Adding to the differential diagnosis. Chest 105: 943-945.
5. Bush A, Collins JV (1982) Pulmonary Munchausen's syndrome. Postgrad Med J 58: 564-565.

This article was originally published in a special issue, **Atherosclerosis** handled by Editor(s). Prof. Andriana Margariti, Kings College London, United Kingdom