Hemoptysis and Munchausen Syndrome

To the Editor:

We read with great interest the article by Baktari and colleagues1 that appeared in the March 1994 issue of Chest in which they presented a fascinating case report and excellent review of the literature regarding factitious hemoptysis.

We would, however, like to call attention to our recently published report2 on a 19-year-old woman who presented to our institution with a history of acute hemoptysis. She stated that she had been diagnosed with cystic fibrosis (CF) at age 2 and had a long history of CF-related pulmonary complications, including recurrent hemoptysis severe enough to necessitate blood transfusions and bronchial artery embolization. Medical history was also remarkable for placement of a permanent cardiac pacemaker and an appendectomy. Physical examination was remarkable for mild obesity, shallow respirations, a median sternotomy scar, a few scattered lung cracks, and absence of digital clubbing. Laboratory data were consistent with iron deficiency anemia. Chest radiograph showed clear lung fields without hyperinflation.

After admission, the patient continued to complain of hemoptysis and though none was ever witnessed by medical personnel, her hemoglobin concentration fell. Bizarre behavior, inconsistencies in her stories, a relatively benign physical examination, and laboratory data inconsistent with a diagnosis of cystic fibrosis (including sweat chloride values) made us doubt whether indeed she had CF. After psychiatric consultation, a diagnosis of Munchausen syndrome was made. Records from other hospitals eventually revealed that during one admission for hemoptysis, a dark substance the patient claimed to have expectorated was found to be a mixture of iodine solution and shampoo. Actual hemoptysis was never documented.

Our case differs from that of Baktari et al in that our patient did indeed have laboratory evidence of iron deficiency anemia. However, we believe it was not secondary to chronic hemoptysis, but rather self-phlebotomy, a speculation supported by the presence of multiple antecubital scars and noniatrogenic ecchymoses. Therefore, in any patient presenting with a history of hemoptysis, the possibility of factitious illness should always be considered, even in the presence of laboratory data suggesting substantial blood loss.

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REFERENCES


To the Editor:

I agree with Dr. Rusakow and his colleagues that their case differs from ours in that their patient had abnormal laboratory values and that this, in fact, does not exclude the diagnosis of factitious hemoptysis. However, there is one aspect of both of our case reports that are very similar and unfortunately rare. Both cases involved the physician investigating and exposing the attempt at subterfuge by the patient. It appears that most physicians for understandable reasons do not wish to play “Sherlock Holmes.” Instead, when they finally realize that their patient has a possible factitious illness, the general response in most cases in our review was to quickly discharge the patient from the hospital with no further investigation. Some physicians appear to want to cut their losses short, i.e., too much time wasted on a nonorganic problem, while other physicians believe that they were ethically handcuffed to check with or warn other physicians in their community. Some physicians took their struggle with ethics one step further. After submitting our report for publication, we found that the patient involved in our case was admitted to a county hospital in our region. Our attempt to communicate our findings of 23 previous hospital admissions and 16 previous bronchoscopies appeared not to be welcomed. Apparently, the patient went on to receive a diagnostic workup anyway.

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