**Fooling the doctors.**

In 1967, the year I finished High School, South Africa did away with the ballot system for National Service and made it compulsory for all males leaving High School to do National Service for nine months. Those students going on to University could have the National Service deferred until after completion of their studies. During the last year at High school I went with hundreds of other 17 and 18-year olds from the area to the local drill hall for a medical examination prior to National Service. We stood in a line and at various stages had our weight, height, vision and urine checked. The last stage was standing naked, feeling very vulnerable, on the stage in front of a desk where the physician reviewed the testing and did a cursory examination of our heart, lungs, and hernial sites etc. He noticed the purple scar on the outside of my knee where I had had surgery for osteomyelitis a few weeks before.

“Does your leg bother you?” he asked.

“It’s a bit painful when I walk a lot” I replied. This was true at the time. I did not state that it was getting better.

“Well, I cannot exempt you from going to the Army, but I can recommend you do not do any marching.” He said. I was delighted. I had heard enough about the process of military training to know that the first few months of basic training in any army is marching, marching and more marching as well as physical activity. It would be nice to escape that drudgery.

A month or so later I received a card in the mail, stating that I was medically unfit and that I was not required to inform the authorities of any change in address. This was better than I could have expected. My life was not going to be wasted by doing what I regarded as a waste of time. The reason for the low threshold for accepting disability at the time was that the army was not prepared for such a large influx of trainees in the first year the ballot system was abolished, so were looking for reasons not to accept trainees. This situation changed later.

I was relating this story later to a fellow physician, also a South African, of my age, who did two years National Service after he qualified at medical school. At that stage South Africa was conducting a low intensity war in Angola. He informed me that by the time he was in the army, medical examinations were no longer done beforehand, as in my circumstance, but were done when the recruit arrived in the camp, and now done by army physicians such as himself.

He related one young recruit who presented himself for examination and stated he had mitral stenosis, a condition caused by rheumatic fever where the mitral valve becomes severely narrowed. He pulled out a packet of radiographs and stated: “here are my chest X-Rays.”

Most patients do not know fancy medical terms, nor anatomy and such a statement of “mitral stenosis” out of the blue, should have raised an eyebrow, but my friend, fresh out of medical school and internship immediately got interested. This was something out of the tedium of examining normal healthy males. He looked at the chest radiographs. It had the name of the patient and yes, many of the radiographic features of mitral stenosis, were present. There was the shadow of a bulge just below the aortic knuckle, the bronchi were splayed and on the lateral radiograph there was visible the shadow of a large left atrium. My friend related that he was quite proud of his auscultatory ability and set his stethoscope against the young man’s chest. Try as he could, he could not elicit the opening snap, loud first heart sound and diastolic murmur typical of the condition. He turned the patient on his side, he got him to squat and stand, but still could not hear the murmur. How strange he thought. He picked up the chest radiograph again. The name was the same. On the second review of the chest radiograph he noted additional signs of mitral stenosis – there were also Kerley-B lines indicating pulmonary congestion. What can be going on he thought? Perhaps he was not as good a clinician as he thought he was.

“I will need to have you seen by one of our specialists” he said.

The referral was set up and a few days later my friend was called to the cardiologist’s office. He went with some trepidation, wondering what he may have missed.

“You were absolutely correct,” the cardiologist stated immediately. My friend was immediately reassured. “The X-Ray is textbook mitral stenosis.” He paused for a few dramatic seconds: “You are also correct in that the patient has no murmurs and does not have mitral stenosis.” How can this be, my friend thought confused? Again another, but longer pause: “The chest radiograph is from someone who is in his 50’s. It is from the recruit’s father who has the same name. The recruit is trying to pull a fast one. He is just trying to get out of doing military service.” He said laughing. My friend had missed the radiographic calcification of the costal cartilages which typically involves the first costal cartilage at the age of roughly 20 years and then progressively involves more costal cartilages. The extent of calcification can be used to get a rough idea of age. This fact is known to forensic pathologists when they try and age a corpse.

In my own medical career, I have been in contact with three patients who tried to fool the doctor. Undoubtedly, there probably were more who may have been successful in fooling me, but these numbers are obviously unknown. In two patients an ulterior motive existed, similar to the soldier who was trying to avoid military service, but the other patient had Munchhausen’s syndrome, named after Baron Munchausen (Karl Friedrich Hieronymus Freiherr von Münchhausen, 1720–1797) who purportedly told many fantastic and impossible adventures about himself. The patient with this syndrome creates symptoms of illnesses to gain investigation, treatment, attention, sympathy, and comfort from medical personnel.

Many people suffering from Münchhausen's syndrome become highly knowledgeable about the practice of medicine and are able to produce symptoms and clinical signs that result in lengthy and costly medical analysis, prolonged hospital stays and even unnecessary operations. It appears that the role of "patient" fills a psychological need in people with this syndrome and is comforting. It is distinct from hypochondriasis in that patients with Münchhausen syndrome are aware that they are exaggerating, whereas sufferers of hypochondriasis believe they actually have a disease.

Approximately nine months after I had qualified as a medical doctor and while doing the rotation in General Surgery as an intern, I was called to see a young black woman with abdominal pain.

The patient was rather thin and looked anxious. “Tell me what’s been happening?” I asked.

“Yesterday, I started to get pain here,” she said, pointing to the middle of the abdomen, “and then it moved and got worse.”

My patient replied, “it moved down here,” pointing to the lower right abdomen. As she pointed, she grimaced and “ahhed” as if she was in pain.

At this point I was starting to form a differential diagnosis. Appendicitis typically starts with a cramp-like pain in the area of the umbilicus and then moves to the lower right portion of the abdomen, the right iliac fossa, and because her symptoms fit reasonably well, this diagnosis was top of the list, given its frequency. Other possible diagnoses include pelvic inflammatory disease, a urinary tract infection, a ruptured ectopic pregnancy, or dysmenorrhea – pain associated with menstruation. Questions were asked about these other possible diagnoses. She did not have any symptoms of a urinary tract infection. There was no increased frequency of urination, no burning when she urinated and no odor. She had just completed her menstrual cycle, which was always regular and painless. This excluded the possibility of a ruptured ectopic pregnancy. It seemed like my prime diagnosis, appendicitis, was going to be the diagnosis.

I started to examine her. She had no fever. Her pulse was 60 and regular, which did not fit for someone with an inflamed appendix. When I examined her, she grimaced and “ahhhed” when I felt the right lower quadrant, but the abdomen was soft. This was not in keeping with appendicitis; she should have tenderness or rigidity in the area. Also, when pressing on the left side she had no pain in the right iliac fossa – Rovsing’s sign. I lay her on her side and extended the right leg to stretch her psoas muscle – if the inflamed appendix is lying on the psoas muscle pain is aggravated by this maneuver. She did not have pain. I then did a vaginal and rectal examination. There was no evidence of vaginitis and she was not tender.

I concluded at the end of the examination that the patient had a good history for acute appendicitis but had none of the classic clinical signs. I told her: “I am not sure what is going on. I think it best we admit you to hospital, do some tests and observe what is happening.” I could not send home a patient with suspected appendicitis.

The patient’s urine examination was clear. She did not have a urinary tract infection. Her white cell count was in the normal range. If appendicitis had been present it is usually elevated. I did a plain abdomen radiograph. It was completely normal. There were no radiographic features of an ascaris lumbroides worm infestation which we occasionally saw, and which could cause pain in this area. There was no radiopaque kidney stone. I examined the patient several times that first day, but there was nothing to indicate she should go to the operating room.

The following day on rounds it was documented that the patient had a swinging fever, but she looked relatively well. She was lying very comfortably, but still complained of pain in the right lower quadrant. My examination was the same as before – nothing conclusive. I repeated the urine and lab tests – they were still normal. What is going on I thought. I did know that there was not enough evidence for surgical intervention. I consulted my colleagues who shared my opinion. We continued observation. Her fever continued with swings sometimes up to 103 degrees Fahrenheit and her clinical signs were unchanged. I explained to the patient: “I am concerned there is something happening, but I do not know what. I think we have to have to watch a while longer.”

“Why don’t you just operate and look inside?” she asked.

“That is a drastic step, and if we find nothing, we will be exposing you to pain and risk of the operation.” I replied.

We decided to watch her another night and if she still had pain the following day then we would explore her abdomen and deal with what we found.

The next day we had our answer. One of the nurses had noticed the patient furtively hiding something under her pillow. When she looked she found an extra thermometer.

When confronted the patient sheepishly admitted to making up the pain as well as creating her fever. She swapped thermometers when the nurse was not looking. The one thermometer she retained was heated in tea or coffee and was the reason for the fever.

“Why did you do it?” I demanded. I was appalled that someone would go to such steps and even be prepared to have surgery. “We were about to take her to the operating room!” I exclaimed.

“I just want to have a baby,” she said. “My husband wants children, but we have not been able to. I want you to look inside and see if there is anything wrong.” On closer questioning we elicited the fact that she had previously been treated for gonorrhea and pelvic inflammatory disease and did not want her husband to know. We arranged further testing which confirmed that her fallopian tubes were diseased. We did this testing without sharing the information with her husband.

The second patient followed soon after the one previously described. Again, she was a young black woman in her twenties. She had been admitted because she had been coughing up blood. Hemoptysis, or the coughing of blood, was quite common and the most common reason was tuberculosis. In some patients the hemoptysis can be large and may require emergency surgery to deal with the problem. In some patients the bleeding can be so severe that the patient drowns in their own blood. I sent labs looking particularly if she was anemic – anemia may indicate severity of the hemoptysis and whether blood transfusion was necessary. I tested her blood to be certain she did not have a bleeding tendency. I placed an order that sputum be cultured looking for infection and tuberculosis. I looked at the chest radiograph. It looked normal.

I wondered what the cause for her hemoptysis was given the normal labs and chest radiograph. She was admitted for observation. The next day on rounds she looked well, but in the container next to her bed was approximately a half cup full of bright red blood. Her blood count was repeated, but the hemoglobin was the same – she was, based on the lab testing, not losing much blood.

A bronchoscopy was done. She was anesthetized, and a rigid tube placed in her airway. The trachea and bronchi as far as we could see were clear, without any evidence of inflammation, and without a drop of blood being present. When she woke up, I reassured her: “we could see nothing abnormal.”

The next day at rounds there was another half a cup of blood next to the bed. Had we missed something? Sometimes hemoptysis can be confused with hematemesis the vomiting of blood. We asked her specifically: “when you bring up the blood do you cough it up? do you feel nauseous?”

She reiterated. “I do cough it up.”

We looked specifically in the cup to see whether there were features of sputum or altered food. There was some frothy white fluid which saliva could be, but no food contents. We passed a tube via her nose into the stomach to see if there was any evidence of bleeding within the stomach – there was none. Stool was examined for signs of blood – this was negative. What is going on we wondered?

Out of desperation I sent some of the fluid to the laboratory. An hour later I was contacted by the lab. “The sputum you sent us is not human blood!”

The patient was confronted. “We have analyzed the blood you say you have been coughing up, but it is not your blood. I think you should explain what is going on.”

She looked very sheepish and explained that her relatives were bringing in some chicken blood which she placed in the container each night. “My father died of tuberculosis. He coughed up blood. I want to be certain there is nothing wrong with me.”

The third case occurred in the USA. I was on call and asleep in bed when I received a telephone call in the early hours of the morning. The operator told me she had a patient who was at the Emergency Room of a local hospital asking that he be transferred to Mayo Clinic under my care. To be frank I was a bit annoyed to receive such a call as such a request should come from the physician seeing the patient. “Put him on the line.” I requested.

The patient told me he was 30 years of age and had Ehlers-Danlos syndrome. Ehlers –Danlos syndrome is a hereditary condition characterized by laxity of skin and joints and is associated with aortic dissection. Aortic dissection is a condition where the aortic wall splits. If the extent of dissection involves the ascending aorta this is a medical emergency, because if left untreated may cause death in most patients within 24 hours. Readers in the USA will recall that this disease caused the death of John Ritter, the TV actor who starred in Three’s Company, at the age of 54 years. On hearing this statement, I became more alert and wider awake.

The patient informed me: “I started getting pain in my chest about 8pm. I knew it was my heart as I have had the pain before. I have had two operations on my heart to fix an aortic dissection and I have a residual false lumen. I called 911 but they took me to this hospital, and I am waiting in the ER. I am calling on my cellphone. They are not doing much. I told the paramedics that I needed to go the Mayo Clinic, but they did not listen to me.”

I answered, “The reason the paramedics took you to that hospital is that that is what they are trained to do.” It is important that any person with chest pain go to the closest hospital so that treatment for a possible myocardial infarction can be initiated as soon as possible.

“Are you still having chest pain?” I asked.

“It is slightly better.”

“How did they make the diagnosis of Ehlers-Danlos?” I asked.

“They did a skin biopsy?”

“Where did you have your surgery?”

He replied. “I had my surgery in Houston. The dissection was involving the left main coronary artery and I was told that I was lucky to be alive. I am on treatment with beta blockers and calcium channel blockers.”

I thought to myself. This does not sound right. He is talking like someone who is not having any pain and he also seems too plausible. He talks using language that doctors use amongst themselves, not in the style of a lay person. “What sort of work do you do I asked?” wondering whether he was in the medical field.

“I am in IT he replied. I normally live in New Jersey, but was traveling down to the Keys for vacation, when I got the pain.”

“Have they done any tests,” I asked.

“They have done a CT scan with contrast and I have not heard anything. Doc, I must come to the Mayo Clinic. I need someone experienced to deal with my problem.” He pleaded.

Just then, a bell starting ringing in my head. I recalled a paper that I had read describing a young patient in his twenties who presented to an emergency room in Rhode Island with very similar symptoms who had had two surgical procedures on his heart[[1]](#footnote-1). There was a scar on the patient’s chest and there were wires where the chest had been closed visible on a chest radiograph. I also recalled that the paper stimulated further letters to the Editor from other surgeons who described a similar patient being admitted to their hospital with similar complaints[[2]](#footnote-2),[[3]](#footnote-3). It turned out that it was the same patient who had traveled extensively up and down the east coast of the United States. On some of these visits his chest must have been opened. This patient’s story was sounding very similar to the patient I had read about. I was convinced this was the same patient up to his usual tricks.

I told the patient: “It is inappropriate for you to be transferred. I cannot judge the severity of your illness over the telephone and it would be wrong for you to be transferred if you are as sick as you claim. The institution you are in has cardiothoracic surgeons. If they do not feel they can deal with your problem they will contact me.”

After I put down the phone I started laughing. My wife woke up and I tried to explain the situation. Of course, she did not see the humor behind the situation and said, “But, what if he had a dissection?” Momentarily, I had doubts and wondered whether I had done the right thing, but I was certain in my mind that I was correct.

The next day, I found the report and contacted the admitting physician at the hospital and apprised him of my suspicions. I was told that it was the same patient. There was a scar on his chest where it had been opened and another CT scan had confirmed the absence of a dissection. The patient had signed himself out as soon as the questions had become more pointed. Why such a patient will travel around the country having repeated CT scans and even chest surgery is difficult to imagine.

1. Hopkins RA, Harrington CJ, Poppas A. [Münchhausen Syndrome simulating acute aortic dissection.](https://www.ncbi.nlm.nih.gov/pubmed/16564304)

   Ann Thorac Surg. 2006;81:1497-9. [↑](#footnote-ref-1)
2. Fedoruk LM, Kern JA. [Munchausen syndrome and acute aortic dissection: letter 1.](https://www.ncbi.nlm.nih.gov/pubmed/17062291) Ann Thorac Surg. 2006;82:1948; author reply 1948-9.  [↑](#footnote-ref-2)
3. Estrera AL, Safi HJ. [Munchausen syndrome and acute aortic dissection: letter 2.](https://www.ncbi.nlm.nih.gov/pubmed/17062290) Ann Thorac Surg. 2006;82:1948; author reply 1948-9.  [↑](#footnote-ref-3)