A Case of Malingering: Feigning a Painful Disorder in the Presence of True Medical Illness

John T. Chang, BS, Jill A. Szczyglinski, BS, and Steven A. King, MD, MS
Division of Pain Medicine and Department of Psychiatry, Temple University School of Medicine, Philadelphia, Pennsylvania

Abstract

The potential for malingering must always be considered among patients presenting with pain. When malingering is identified, care may be discontinued. This case report describes a patient who feigned sickle cell crisis, a painful condition, in the presence of other identifiable and potentially painful medical illnesses.

Key Words: Malingering; Pain Disorder; Sickle Cell Disease; Opioid Abuse

Because pain is a subjective complaint, the possibility that patients complaining of it may be falsifying or exaggerating their suffering always exists [1,2]. The goal of the deceit may be to obtain medical care, as occurs in factitious disorder, or to achieve an external goal such as financial gain or obtaining medications that may be abused, as occurs in malingering. When malingering is identified, medical treatment is usually terminated. However, the possibility that a patient with actual, potentially painful medical illnesses may feign an additional illness for external gain has not been addressed in the literature. The following is a case report of feigned sickle cell disease by a patient with other medical conditions.

Case Report

A 35-year-old African-American male presented to Temple University Hospital Emergency Department (ED) complaining of severe, diffuse pain in his chest, arms, and legs typical of a sickle cell crisis. The patient also reported that he had been experiencing nausea, vomiting of dark red blood, and crampy abdominal pain for the previous few days. The patient gave a medical history of pancreatitis, osteomyelitis of the knee, esophagitis, renal insufficiency, diabetes mellitus, sickle cell disease, deep vein thrombosis, Crohn's disease, and anemia; surgical history included placement of an IVC filter, below-the-knee amputation of the right leg, and thoracic surgery.

Physical exam was remarkable only for mild right upper abdominal tenderness. His abdomen was otherwise soft and nondistended, with no masses. Rectal examination showed brownish stool that was positive for occult blood. Hematocrit was 27.9%. Blood glucose was 503 mg/dL. White blood cells were 14,700 per mm$^3$. Blood urea nitrogen was 39 mg/dL, and creatinine was 2.7 mg/dL. Other chemistries were within normal limits.

In the ED, the patient refused nasogastric lavage several times. To clarify the nature of his previous thoracic surgery, consent to transfer old records from a second Philadelphia hospital was requested, but the patient refused. After admission to the medical service, various diagnostic procedures were performed. An abdominal radiograph verified the presence of an IVC filter but found no evidence of disease. Endogastroduodenoscopy revealed esophageal erythema suggestive of Candidal esophagitis and a mass lesion near the gastroesophageal junction. MRI was scheduled for evaluation of left knee pain, but the patient refused.

On the second day of admission, the patient agreed to consent to transfer of old records from the second Philadelphia hospital. However, no record of the patient was found; the patient subsequently admitted to using multiple aliases at various hospitals, and supplied these names. Medical records revealed 21 hospitalizations at the second Phila-
White blood cells were 9,300 per mm$^3$, hematocrit was 27.9%. Blood glucose was 1184 mg/dL. Pus was noted in the Foley catheter bag. Hematoma was otherwise soft and nondistended. Rectal exam revealed mild right upper abdominal tenderness. His abdomen was otherwise soft and nondistended. Physical examination was remarkable only for mild right upper abdominal tenderness. His abdomen was otherwise soft and nondistended. Rectal examination showed heme-positive stool. Frank pus was noted in the Foley catheter bag. Hematocrit was 27.9%. Blood glucose was 1184 mg/dL. White blood cells were 9,300 per mm$^3$. Blood urea nitrogen was 32 mg/dL, and creatinine was 2.7 mg/dL. Results of other chemistries were within normal limits. After admission to the medical service, various diagnostic procedures were performed. Radiograph of the tibia and knee demonstrated joint space abnormalities consistent with trauma, but there was no evidence of osteomyelitis. Vascular Doppler studies revealed deep vein thromboses in the left superficial femoral and popliteal veins. Urine culture grew yeast.

On the third day of admission, a member of the medical team taking care of the patient on the previous admission fortuitously walked into the patient's room and recognized the patient. He revealed to the current medical team that the patient had been admitted numerous times to Temple University Hospital under different names complaining of diffuse sickle cell crisis pain in his joints over the previous few days. The patient also complained of cough productive of green-yellow sputum and pleuritic right-sided pain. The patient gave a past medical history of diabetes mellitus, sickle cell disease, and peripheral vascular disease.

The following day, the patient was brought in by ambulance. Using a different alias and failing to reveal that he had just been hospitalized, the patient complained of diffuse sickle cell crisis pain in his joints over the previous few days. The patient also complained of cough productive of green-yellow sputum and pleuritic right-sided pain. The patient gave a past medical history of diabetes mellitus, sickle cell disease, and peripheral vascular disease.

Physical examination was remarkable only for mild right upper abdominal tenderness. His abdomen was otherwise soft and nondistended. Rectal examination showed heme-positive stool. Frank pus was noted in the Foley catheter bag. Hematocrit was 27.9%. Blood glucose was 1184 mg/dL. White blood cells were 9,300 per mm$^3$. Blood urea nitrogen was 32 mg/dL, and creatinine was 2.7 mg/dL. Results of other chemistries were within normal limits. After admission to the medical service, various diagnostic procedures were performed. Radiograph of the tibia and knee demonstrated joint space abnormalities consistent with trauma, but there was no evidence of osteomyelitis. Vascular Doppler studies revealed deep vein thromboses in the left superficial femoral and popliteal veins. Urine culture grew yeast.

On the third day of admission, a member of the medical team taking care of the patient on the previous admission fortuitously walked into the patient’s room and recognized the patient. He revealed to the current medical team that the patient had been admitted numerous times to Temple University Hospital under different names complaining of diffuse sickle cell crisis pain in his joints over the previous few days. The patient also complained of cough productive of green-yellow sputum and pleuritic right-sided pain. The patient gave a past medical history of diabetes mellitus, sickle cell disease, and peripheral vascular disease.

Physical examination was remarkable only for mild right upper abdominal tenderness. His abdomen was otherwise soft and nondistended. Rectal examination showed heme-positive stool. Frank pus was noted in the Foley catheter bag. Hematocrit was 27.9%. Blood glucose was 1184 mg/dL. White blood cells were 9,300 per mm$^3$. Blood urea nitrogen was 32 mg/dL, and creatinine was 2.7 mg/dL. Results of other chemistries were within normal limits. After admission to the medical service, various diagnostic procedures were performed. Radiograph of the tibia and knee demonstrated joint space abnormalities consistent with trauma, but there was no evidence of osteomyelitis. Vascular Doppler studies revealed deep vein thromboses in the left superficial femoral and popliteal veins. Urine culture grew yeast.

On the third day of admission, a member of the medical team taking care of the patient on the previous admission fortuitously walked into the patient’s room and recognized the patient. He revealed to the current medical team that the patient had been admitted numerous times to Temple University Hospital under different names complaining of diffuse sickle cell crisis pain in his joints over the previous few days. The patient also complained of cough productive of green-yellow sputum and pleuritic right-sided pain. The patient gave a past medical history of diabetes mellitus, sickle cell disease, and peripheral vascular disease.

Discussion

The conscious falsification of medical symptoms is a primary feature shared by malingering and factitious disorder. Therefore, both disorders must be considered in the differential diagnosis of this case. According to the fourth edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [3], three criteria are required for the diagnosis of factitious disorder: the intentional production or feigning of physical or psychological signs or symptoms; the motivation for the behavior is to assume the sick role; and the absence of external incentives for the behavior. In contrast, malingering is described in the DSM-IV as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs” [4]. We believe that malingering is the most likely diagnosis in this case.

First, the apparent presence of a clear external gain excludes the diagnosis of factitious disorder. The patient sought and successfully obtained hydromorphone during both hospital stays. When hydromorphone was discontinued, the patient refused to consider alternative analgesics, or to even discuss treatment options with the pain management service, and left the hospital.

Second, though factitious disorders can have myriad presentations [5–7], these patients, in order to maximize their chances of hospitalization, commonly fake diseases in which physical signs or laboratory tests can be manipulated (eg, injection of feces into a joint to simulate fever, sepsis, or leukocytosis) or in which the diagnosis relies primarily on clinical judgment rather than objective laboratory or radiographic findings (eg, multiple sclerosis). Although there have been reports of factitious sickle cell disease [8,9], it is not a common disease to fake when the patient’s motivation is to remain hospitalized, as sickle cell disease is easily diagnosed by a simple blood test. In contrast, sickle cell crisis is an excellent choice for a malingerer, as it is commonly treated with narcotic analgesics in the emer-
gency department and during hospitalization, prior to discovery by the medical service.

The multiple medical problems reported by this patient could also be symptoms of somatization disorder. However, the identification of actual medical etiology for his physical complaints rule out this diagnosis. His refusal to cooperate with the medical evaluation also makes this diagnosis unlikely. The possibility also exists that the patient truly believed he suffered from sickle cell disease, but despite medical evidence to the contrary, his psychopathology prevented him from accepting it. Here, too, the level of the patient’s dishonesty, his hesitancy to allow his physicians to obtain information on his past medical history, and his uncooperativeness would weigh against this.

The patient described in this report had multiple medical conditions, including hyperglycemia secondary to diabetes mellitus, recurrent deep vein thromboses, and a urinary tract infection during the two hospitalizations described. Medical records from the second Philadelphia hospital confirmed a recent admission for right lower lobe pneumonia and surgical decortication of a right loculated empyema. It appears likely that this patient had additional medical problems, although it remains possible that some of his presenting symptoms (e.g., chest pain, hematemesis) were exaggerated or simply false. The presence of true, coexisting medical illnesses has been noted in patients with factitious disorders (10) but has not been addressed in malingering patients. It seems reasonable to assume that malingering patients who already have true medical illnesses need not fake a second illness. Indeed, it is difficult to understand why our patient chose to fake sickle cell crisis, given that he already had two medical conditions that could have been exaggerated to obtain opioid analgesics. A trial of narcotic analgesics might have been warranted in the treatment of phantom limb pain or severe diabetic neuropathic pain.

This report suggests that patients who malingering may in fact have underlying medical illnesses. Unfortunately, the diagnosis of malingering may not only result in the appropriate termination of future evaluations and treatments for this patient’s nonexistent sickle cell disease, but may also prevent him from obtaining needed treatment for his other medical problems. Since the patient’s apparent goal in falsifying complaints was to obtain hydromorphone, it is quite likely that he suffered from opioid abuse and possible dependence. At the least, his substance use problems may have interfered with his compliance with treatment for his other actual medical problems and may have exacerbated or even caused some of them.

Despite the reactions that patients who malingering often engender from staff and physicians, it may be important to identify and treat any illnesses in these patients, both medical and psychiatric.

References