A 39-Year-Old Man with Polymicrobial Bacteremia

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The patient is a 39-year-old man with chronic hereditary pancreatitis who presented to the emergency department and was hospitalized for abdominal pain, poor oral intake, and fever to 39.8°C (103.6°F). Cultures obtained from various port sites during the first 6 days of admission revealed gram-variable rods and cocci, including Staphylococcus aureus, Streptococcus viridans, microaerophilic Streptococcus, Lactobacillus, and diphtheroids, in addition to Candida. In an effort to provide broad-spectrum antimicrobial coverage, the patient’s physicians administered vancomycin, caspofungin, and piperacillin/tazobactam therapies, which were given through a peripherally inserted central catheter (PICC).

Fourteen years prior to admission, the patient was diagnosed with hereditary pancreatitis. Genotyping revealed a SPINK1 N34S mutation, and the patient’s father (whom he had never met) reportedly had the same condition. At that time, the patient began seeing a therapist to help him cope with his pancreatitis; he denied receiving any psychiatric diagnosis and was not placed on psychotropic medications. From the time of diagnosis until 14 months before this current presentation, the patient was reportedly hospitalized only twice (in two different states) with acute pancreatitis. Thereafter, his use of hospital services increased dramatically, being hospitalized on 10 occasions, ranging from 3 to 25 days. Twice during these admissions, he developed polymicrobial infections and sepsis requiring admission to the intensive care unit.

One week into his latest admission, a nurse witnessed the patient tampering with his PICC line. When unit staff addressed this concern with the patient, he angrily threatened to leave the hospital. This prompted a referral to the psychiatry consultation service to assess his capacity to leave against medical advice. The patient demonstrated sufficient capacity to do so, but decided to remain in the hospital for treatment, at which time a 24-hour aide was ordered to observe his behaviors.

On hospital day 11, the patient’s primary providers called the psychiatry consultation service after another series of suspicious events: the attendant witnessed the patient tampering with his PICC line; a physician noticed a “cylindrical object” in a pillow that the patient brought from home; and a subsequent room search revealed tourniquets and vials of unknown liquids that the patient claimed were apple juice. Furthermore, oral and axillary measures of temperature revealed

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persistent fever, whereas rectal temperature was normal, suggesting possible manipulation.

During his second assessment by the psychiatry consultation service, the patient was polite and cooperative. He denied line tampering and said he was “prone to weird infections.” He reportedly could not make sense of the circumstances and denied engaging in any behaviors that would potentially prolong his admission (“I’ve got a wife and two kids. Why would I want to be here?”) His wife, who was contacted with the patient’s permission, supported his assertion that he hated being hospitalized; she added that she frequently had to convince the patient to be evaluated in the hospital. The patient’s wife did not suspect any illness-interfering behaviors and asserted that he was appropriately upset and puzzled by his repeated infections. Review of medical records from 5 and 13 months prior to admission revealed documentation of suspected line tampering; this was not pursued or discussed in the discharge summary.

In response to suspected line tampering, the primary team converted antimicrobial therapy to oral agents, allowing for removal of the patient’s PICC line. The patient was discharged home on hospital day 14, after being afebrile for 24 hours. Despite the patient’s subjective report of no prior or active psychiatric symptoms, he agreed to follow up with the therapist he had seen years earlier in an outside hospital system. He has not returned to the medical center since this discharge.

**DISCUSSION**

Given its inherently elusive nature, factitious disorder is difficult to identify and arguably even harder to treat. Munchausen’s syndrome, the most severe and chronic form of the disorder, has not been recognized as a psychiatric disorder but is widely known in medicine. This syndrome includes peregrination (frequent geographic moves) and pseudologia fantastica (pathologic lying).  

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) diagnostic criteria of Factitious Disorder Imposed on Self include (1) falsification of physical or psychologic signs or symptoms, or induction of injury or disease, associated with identified deception; (2) presenting to others as ill, impaired, or injured; (3) deceptive behavior that is evident even in the absence of obvious external rewards; and (4) behavior that is not better explained by another mental disorder, such as delusional disorder, or another psychotic disorder.

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) estimates prevalence at 1% of patients referred to a psychiatry consultation service, and DSM-5 suggests that rates may be as high as 1% of all hospitalized patients. A 1990 review by Sutherland and Rodin of 1,288 consecutive patients referred to a psychiatry consultation service in Ontario, Canada, reported an incidence of 0.5%, and a 1998 study by Kapfhammer et al. of 15,000 hospitalized patients seen in psychiatric consultation in Germany reported an incidence of 0.6%.

The differential diagnoses for factitious disorder remain broad, and typically include an underlying medical illness, conversion disorder, somatic symptom disorders, and malingering. In the case of this patient, the possibility of malingering was considered, although no clear secondary gain could be identified for this gentleman who was already receiving disability and had no pending legal concerns, and whose symptoms did not result in additional doses of narcotics or mood-altering substances. The patient’s blithe indifference to accusations, his repeated hospitalizations with similar presentations, and witnessed manipulations made factitious disorder the most probable diagnosis.

Historically, factitious disorder has been described in health care workers and those connected to the medical profession, from which the knowledge and skills are acquired to produce a plausible illness. Relatives of health care workers with factitious disorder have also been reported, as have caregivers who develop factitious disorder after resolution of their loved one’s illness. In comparison, our patient possessed a breadth of medical knowledge that he gained from his own hos-
pitalizations for an unrelated chronic medical condition. Relatively few cases have been published of factitious disorder in patients with an underlying medical disorder, and most detail exaggeration of the underlying disorder, most commonly factitious hypoglycemia in patients with diabetes. Recently, the Internet has been recognized as an important source of information for patients with factitious disorder, as well as medical records and radiographic images. A newly described phenomenon of “Munchausen’s by Internet” has emerged, in which patients infiltrate disease-specific online forums and form relationships with sufferers and caregivers.

Factitious disorder remains a challenging, and often frustrating, diagnosis for health care providers. Identification is made difficult by patients’ hesitation or inability to admit to symptom production, and often poor insight into primary motivations. Treatment has traditionally focused on engagement with one primary provider, who can act as the gatekeeper for hospitalization, in addition to minimizing unnecessary tests and procedures, treating comorbid psychiatric and personality disorders, and providing nonjudgmental direction toward psychiatric treatment. At the same time, given the paucity of patients who admit to symptom production or accept psychiatric help, no psychiatric therapy has been systematically studied in patients with factitious disorder, and no consensus has been reached about how to treat these challenging patients. For now, we must rely on anecdotal reports of therapeutic benefit using behavioral and psychodynamic techniques.

REFERENCES