FORUM

Innocence revisited – 14

Since her days as a medical registrar, Professor Gillian Shenfield has been haunted by the following triad of cases...

Triple jeopardy

There is evidence that events become imprinted in medium and long term memory if associated with some form of intense emotion. This may be why one remembers one's diagnostic mistakes with greater clarity than one's successes. For me, this is especially true of three similar patients…

The traumatised traffic warden

I was a very junior medical registrar and for the first time I was being trusted to see new outpatients. In came a fit looking 36-year-old woman who immediately burst into tears.

She was a traffic warden who six weeks earlier had been issuing a parking ticket when the driver of the car in question returned. He had punched her until she had fallen to the ground and had then driven off.

Since that episode she had been anxious and tearful, had lost her appetite and had vomited most things that she had eaten. Not surprisingly, she had lost weight. She was also sleeping very badly and had been unable to return to work.

There was nothing else of significance on taking her history and I could find no abnormalities on physical examination.

I fancied myself as an empathic person who could cope with obvious psychological problems. I explained, at length, how physical symptoms could occur with emotional stress, that the unfortunate episode was more than enough to have produced her problems and that everything would eventually settle down. I prescribed Valium – it was 1969 – and made an appointment for her to see me in a month. 'A very interesting example of psychosomatic medicine', I thought.

Three weeks later, I was stopped in the corridor by one of the surgical registrars.

'You know that traffic warden you saw three weeks ago?', he asked. 'We admitted her last night with obstructive pyloric stenosis due to extensive gastric carcinoma. She had an obvious abdominal "splash".'

In my mortification, I had to admit that I had not listened for it.

She had radical surgery and I lost track of her when I moved on, but I have little doubt that her prognosis was poor.

The little old lady

Some years later, I was a senior medical registrar in another city. I admitted a frail and emaciated 72-year-old woman whose presenting complaints were weakness and loss of appetite.

The only obvious physical abnormalities were kyphosis and a malnourished appearance. Initial investigations revealed mild iron deficiency anaemia and an exceptionally low serum potassium level of 1.7 mmol/L.

The next day, I took the history again. She had an evasive, withdrawn manner and was reluctant to answer questions but denied any vomiting or diarrhoea and in spite of my best efforts would not admit to the use of aperients or diuretics. I ordered a number of investigations and asked a general surgeon to see her – in case she had a bowel polyp.

This was well before the days of fibreoptic endoscopy and

Professor Shenfield, MA, DM, FRACP, FRCP, is Clinical Professor in Clinical Pharmacology, University of Sydney, Royal North Shore Hospital, Sydney, NSW.
This series is being extended by popular demand. Please send your favourite anecdotes to the Editor, Dr John Ellard, for consideration.

after a week of repeated questions, numerous blood tests, examination by several specialists and attempts to force her to confess to some form of medication abuse, her potassium remained low and we had no diagnosis.

Then one of the nurses reported that she had seen the patient putting her fingers down her throat to make herself vomit. Now we knew…she was obviously a slightly mad little old lady who, for reasons best known to herself, liked the attention of hospital care and was ensuring that her self-induced disease was a prolonged one.

That night, she was found dead in bed. A postmortem revealed major inhalation of gastric contents, complete obstruction due to benign pyloric stenosis and a stomach so large that the rest of her gut had been pushed into one small corner of her abdominal cavity.

I had done it again. Although this time I had listened for a splash, I had failed to appreciate that if the stomach is that large, and that full, the sign is absent.

BARRY OLIVE

The pleasant young woman

Some months later, a 24-year-old woman was admitted to the coronary care unit with severe, uncontrollable arrhythmias and a serum potassium level of 1.2 mmol/L. Her history was of normal health until a couple of weeks earlier when she had begun to feel progressively weak and tired. The day before admission she became aware of frightening irregularities of her heart.

She had no history of vomiting, diarrhoea or kidney problems. On examination she was thin but not emaciated and there were no abnormal physical signs. This time, I was going to get it right. In the unit, neither rigid gastroscopy nor a barium meal were viable options but, daily, I performed vigorous abdominal shaking to listen for the (nonexistent) splash.

Neither physical nor psychiatric disorders necessarily present in obvious ways and two things that seem the same may be very different indeed.

While the cardiologists struggled to control her arrhythmias, we gave her copious amounts of intravenous potassium and sent off a barrage of investigations. Over the next week, I tried to establish a more detailed history but in a frank, open and honest manner she regretted that she could not think of anything else that might be helpful. She was very compliant and often apologised for the trouble she was causing.

Thankfully, I was at a very distant part of the hospital when a junior nurse had the misfortune to open the vanity case that had lain under the bed throughout the admission. It was full to the brim of one week's accumulated vomit.

I had been wrong again, although at that stage in my career I had never heard of bulimia. The patient was no longer able to deny the truth and was referred to the psychiatrists.

It remains a total mystery to me how someone, in full view of the nursing staff 24 hours a day, could have maintained the deception so successfully.

What does it all mean?

This triad of cases has haunted me ever since. I would like to think that they have made me a better diagnostician but I am not sure that is the case. What they have done is convince me that neither physical nor psychiatric disorders necessarily present in obvious ways and two things that seem the same may be very different indeed. MT

Next month, we bring you a further tale of misdiagnosis.