reducing the febrile syndrome while the dyspnoea continued.

Therapeutic and diagnostic thoracentesis was performed, with transudate characteristics. We found greater glucose in pleural fluid than in plasma. Dyspnoea improved and peritoneal fluid was cultured, showing negative results.

Given the suspicion of pleuroperitoneal communication, an isotopic peritoneogram with 99mTc-MAA was performed. The presence of the radiotracer activity at the right hemithorax suggested the existence of pleuroperitoneal communication in this hemithorax (Figure).

Having confirmed the diagnosis of pleuroperitoneal communication, it was decided to temporarily suspend PD and the patient was transferred to haemodialysis.

DISCUSSION

Patients on PD may present technique-related complications, the most frequent being peritonitis, catheter-related infections, hernias; and among the less frequent ones is pleuroperitoneal communication.2.3 This occurs by congenital or acquired diaphragmatic defects, due to an increase in intra-abdominal pressure when instilling peritoneal fluid. This can also be associated, in some cases, with peritonitis episodes.1 Its incidence rate ranges between 1.6% and 2%, although it is believed to be greater in some cohorts. It is more frequent in women and on the right-hand side. Our patient is a male who presented right pleuroperitoneal communication, and whose diagnosis was reached due to the clinical suspicion in the presence of dyspnoea, hypoventilation, and decreased ultrafiltration.[2]

Chest x-ray revealed pleural effusion. The thoracentesis showed a liquid with characteristics of fluid transudate, and the concentration of glucose in pleural fluid was greater than in plasma.[2.3]

The isotopic peritoneogram with 99mTc-MAA, showing pleuroperitoneal communication, was very useful for confirming the diagnosis.[4]

Before diagnosis other causes of dyspnoea should be ruled out, such as salt retention, heart failure, hypoproteinaemia, infections or neoplasias.[3]

Treatment consists of the final or temporary cessation of PD, with peritoneal rest and transition to haemodialysis. In some cases where the patient maintains residual diuresis, you may continue automated PD (APD) at low volumes or APD at low volumes with dry day. In some occasions, it is necessary to perform pleurodesis, either chemical (tetracycline), surgical or with the patient's blood.[5]

In our case, the decision was peritoneal rest with temporary transition to haemodialysis.

In some cases, treatment does not deliver good results, giving rise to the abandonment of the technique (PD) and the final transition to haemodialysis.

Conflicts of interest

The authors affirm that they have no conflicts of interest related to the contents of this article.

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31 year old woman with Munchausen syndrome in haemodialysis. Case report and literature review

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To the Editor,

Factitious disorders (FD) and malingering (M) include people who, deliberately, pretend or produce diseases to assume the role of sick, portraying symptoms or signs that may be physical, psychological or both.[1] On FD there is no demonstrable external incentive and this practice is more predominant in women. Malingering patients look for a secondary gain and it

is more frequent in men.[2] Both disorders overlap and may be difficult to distinguish. Sometimes they are called Munchausen syndrome (SM)[3] and, although the syndrome has not been formally included as a mental disorder,1 it is widely known in medicine. It includes: 1) A factitious chronic disease, which can be severe and disabling; 2) the pilgrimage: individuals change hospitals, cities or country when their objectives are unsuccessful or discovered; 3) pseudologia fantastica: amazing stories are described with complete certainty. Cases have been described in which parents have made their children sick to reap benefits.[4]

We present the case of a 31-year-old nurse on haemodialysis with a permanent pacemaker due to tachycardia/bradycardia syndrome and chronic kidney disease with not well-defined cause, who had been diagnosed a year prior. She checked in at the emergency department reporting fever with chills, anuria and general discomfort.

Physical examination confirmed absence of blood pressure (BP) or pulse in the upper limbs, skin pallor and signs of mild dehydration. Heart rate: 118 beats/min, respiratory rate: 24 breaths/min and temperature of 38.5°C. The haemodialysis catheter showed signs of infection in the insertion site (it was withdrawn and cultured). The rest of the physical examination was normal, with a preliminary diagnosis of septic shock by catheter infection. The treatment included vasopressors and antimicrobials and patient was moved to the intensive care unit (ICU).

Upon arrival to the ICU the adequate skin perfusion contrasted with the diagnosed septic shock. There was no BP in the upper limbs, since arteriovenous fistulae had been created in the forearms without reaching flow, but the lower limps showed a BP of 150/90mm Hg, so the vasopressor treatment was terminated. The patient refused to have a bladder catheter placed. The initially diminished central venous pressure was normalised with hydration and a wide and clear diuresis was recovered.

The analysed found: leukocytosis (18x109/l), anaemia (108g/l) and high serum creatinine (158μmol/l). Other complementary studies, including arterial blood gasometry, ionogram, glycaemia and urine sediment, gave results within the normal limits. The ultrasound showed kidneys and urinary tract of normal size and echogenicity. On the third day, creatinine levels had already reached normal values and there was no evidence of kidney disease. Blood cultures with methicillin-resistant Staphylococcus aureus were performed.

Faced with the evidence, MS was strongly suspected and psychological assessment was requested. In the interview, the patient cooperated but refused to undergo a psychometric evaluation and denied having faked the symptoms or altered samples.

The patient's profession (nursing) allowed her to carry blood samples to the laboratory, where she supposedly would add a few drops of urine to raise the levels of creatinine significantly. On many occasions haemodialysis was not concluded due to "discomfort". Patient always refused to undergo a renal biopsy, despite it being appropiate.5 It is speculated that the dysrhythmia could have been caused by self-prescription heart-rate altering drugs and that arteriovenous fistulae were damaged by the patient.

Days later, she was withdrawn from the haemodialysis programme. To date, she remains asymptomatic and has re-joined social life. Motives could not be determined with certainty.

Table 1. Main observations that point towards malingering and factitious disorders.

- Atypical, dramatic, vague and inconsistent presentation of symptoms although apparently plausible
- Sometimes technical medical words slip out
- Inconsistency between medical history and objective findings
- Perfect descriptions that resemble a medical textbook
- Large number of admissions into different hospitals with a long medical history
- Employed or trained in a branch of medicine
- Visits to the emergency department when the most experienced staff is not available (holidays, in the evenings and weekends)
- Indifferent acceptance of risky and invasive procedures
- Emergence of symptoms only when the patient is being observed
- Abuse of drugs, especially prescription painkillers or sedatives
- Hostile, controlling patients, particularly when they are not heard or when questioned about their background or medical history, or when they are asked documentation as proof of illness
- Apparent development of complications or change in the initial clinical symptoms when the suggested disease has been ruled out

There are certain criteria that allow us to suspect MS (Table). The diagnosis must be done with caution, because a mistake can be fatal. Psychological treatment depends on personality type and the likely aetiology, although in most cases the patients evade treatment.[2]

Mortality rates may be high due to body self-manipulation, complications of procedures, and hiding important medical information; besides, when they really become ill, these patients can be ignored because of their history.[6]

In conclusion, MS should be considered in any patient with inconsistencies between their symptoms and the clinical tests. Although it is a rare disease, its diagnosis is essential for the serious consequences that it can cause on the patient.

Conflicts of interest

The authors affirm that they have no conflicts of interest related to the contents of this article.

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