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TRUST BUT VERIFY: ETHICAL CONSIDERATIONS OF POTENTIAL MISDIAGNOSES AND INCORRECT PATIENT DIAGNOSES

Eric Grisham

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TRUST BUT VERIFY

ETHICAL CONSIDERATIONS OF POTENTIAL MISDIAGNOSES AND INCORRECT PATIENT DIAGNOSES

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Spokane, WA
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CASE ILLUSTRATION

• 40-year-old female, no access to archived records

• PMHx → ESRD on hemodialysis, type 1 diabetes mellitus, gastroparesis, protein-calorie malnutrition, and a distant history of combined bulimia-anorexia and a suicide attempt at 16 years old

• Admitted for workup of hypoglycemia after being found down at home

• PEx →
  • Cachectic, generally weak
  • Encephalopathic, hypoglycemic, hypothermic
WORKUP AND MANAGEMENT

• Clinically she looked improved over the course of several days/weeks
• ECG → Sinus bradycardia
• CT abdomen → ascites, bilateral pleural effusions
• Labs → Pancytopenia, various electrolyte abnormalities
• DDx → Autoimmune hypoglycemia, autoimmune hepatitis, noninsulinoma pancreatico-genous syndrome such as an IGF-1/2 producing tumor, or neuroendocrine tumor such as an insulinoma, hemochromatosis, hemophagocytic lymphohistiocytosis, and autoimmune hepatitis.
WHEN IS DIABETES NOT DIABETES?

- Symptoms of diabetes mellitus type 1 are often nonspecific.
- No DKA in the setting of DM1 not on insulin → was her hypoglycemia truly the result of type 1 diabetes mellitus?
- DM1 with DM1 is most often a delayed diagnosis or misdiagnosis rather than another condition misdiagnosed as DM1

### Table 1. Causes of Diabetic Ketoacidosis

<table>
<thead>
<tr>
<th>Causes of Diabetic Ketoacidosis</th>
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</thead>
<tbody>
<tr>
<td><strong>Drugs</strong></td>
</tr>
<tr>
<td>Antipsychotic agents: clozapine (Clozaril), olanzapine (Zyprexa), risperidone (Risperdal)</td>
</tr>
<tr>
<td>Illicit drugs (cocaine) and alcohol</td>
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<tr>
<td>Others: corticosteroids, glucagon, interferon, pentamidine, sympathomimetic agents, thiazide diuretics</td>
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<tr>
<td><strong>Infection</strong></td>
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<td>Pneumonia, sepsis, urinary tract infection</td>
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<tr>
<td><strong>Lack of insulin</strong></td>
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<tr>
<td>Insulin pump failure</td>
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<tr>
<td>Nonadherence to insulin treatment plans: body image issues, financial problems, psychological factors</td>
</tr>
<tr>
<td>Unrecognized symptoms of new-onset diabetes mellitus</td>
</tr>
<tr>
<td><strong>Other physiologic stressors</strong></td>
</tr>
<tr>
<td>Acromegaly, arterial thrombosis, cerebrovascular accident, Cushing disease, hemochromatosis, myocardial infarction, pancreatitis, pregnancy, psychological stress, shock/hypovolemia, trauma</td>
</tr>
</tbody>
</table>

*Information from references 4, and 10 through 16.*

THE ETHICAL AND SCIENTIFIC CHALLENGE BEHIND MISDIAGNOSIS

- Misdiagnosis may potentially lead to increased morbidity and even mortality \(^1\)
- Healthcare professionals who misdiagnose may experience guilt \(^1\)
- Malpractice lawsuits are difficult for all parties involved, but in particular are feared by healthcare physicians \(^1\)

Ethical Considerations \(^3\)
- Patient Autonomy (self-governance)
- Veracity (truthfulness)
- Justice (fairness)

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CASE OUTCOME

• GJ tube placed for long term nutrition → Bleed from GJ tube
• PEA arrest #1 with quick ROSC after compressions and epinephrine
• Transferred to ICU, intubated → Unable to pass SBT 2/2 apnea + recurrent hypoglycemia requiring dextrose
• PEA arrest #2 with brief ROSC → Comfort measures initiated on ICU day #5
FINAL CONSIDERATIONS

• Complicated, very sick patient
• Unclear final diagnosis
• Care should be made to be truthful to patients, but not at the expense of prior medical treatment
• Ethical principles of care apply to all patients
• Verifying outside records and patient reports is an essential step to every hospital admission
REFERENCES


