REPORTE DE CASO

The VIP patient syndrome in Latin America is known as "The recommended patient syndrome" a tale of unfortunate decisions and complications.

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RESUMEN

Cuando un paciente tiene relación social, económica o familiar con el equipo de salud que lo trata en el servicio de Urgencias existe un riesgo sutil de tomar decisiones poco ortodoxas, además de usar recursos de manera excesiva, romper protocolos de manejo y en el peor de los escenarios causar complicaciones inesperadas al paciente. El síndrome de paciente recomendado es una entidad descrita, consistente en una serie de complicaciones médicas que involucran a un paciente que ha ingresado a una institución y tiene un vínculo económico, social o familiar con los médicos que lo atienden.

Reporte de Caso: reportamos el caso de una paciente de 55 años familiar de un médico de urgencias quien ingresa a emergencias con un cuadro de dolor abdominal, al ingreso se sospecha apendicitis versus masa abdominal. Realizan tomografía abdominal contrastada, y la paciente presenta una reacción alérgica al medio de contraste requiriendo intubación orotraqueal la cual fue selectiva y llevo a una atelectasia masiva. Después de la extubación presenta sobredosis por fentanilo y finalmente estrés postraumático al egreso.

Conclusión: En Latinoamérica el síndrome de paciente recomendado es una entidad que existe, esta poco descrita, en nuestro conocimiento nunca ha sido cuantificada. Los pacientes son víctimas de múltiples complicaciones no malintencionadas, que se originan en el deseo del equipo médico de brindar una atención más cercana, rápida y personalizada. Se puede prevenir fortaleciendo los principios éticos de atención, realizando una historia clínica adecuada y un examen físico detallado.

***Palabras clave*:** recomendado, medio contraste / efecto adverso, fentanilo/toxicidad, intubación /efecto adverso

ABSTRACT

The VIP patient syndrome in Latin America is known as "The recommended patient syndrome" a tale of unfortunate decisions and complications.

When a VIP patient or a patient who has an economic, social or family relationship with the doctors who treat them, arrive to the ER there is a subtle risk of making unorthodox decisions, Also, wasting resources, breaking standards of care and in the lowest scenario causing unintended complications to the patient.

Case Report: We report a 55-year-old patient related to a physician. She was admitted to the emergency room due to abdominal pain, on admission was suspected appendicitis versus abdominal mass, an abdominal CT scan with contrast was performed and she developed an allergic reaction due to the contrast, she required intubation that was complicated with selective intubation and a massive atelectasis. After removal the orotracheal tube she presented fentanyl toxicity and finally after discharge developed post-traumatic stress.

Conclusion: in LA (Latin America) this syndrome is an entity that exists, has been little described and in our knowledge has never been quantified. Patients are victims of multiple non-malicious complications, which originate in the desire of their health team trying to provide a closer, faster and more personalized attention outside of the guidelines of treatment. Ethical principles and prevention should be strengthened through an adequate clinical history and a detailed physical examination to avoid this event.

***Keywords*:** VIP syndrome, contrast media/adverse effect, fentanyl toxicity, endotracheal intubation/adverse effects.

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I. INTRODUCTION

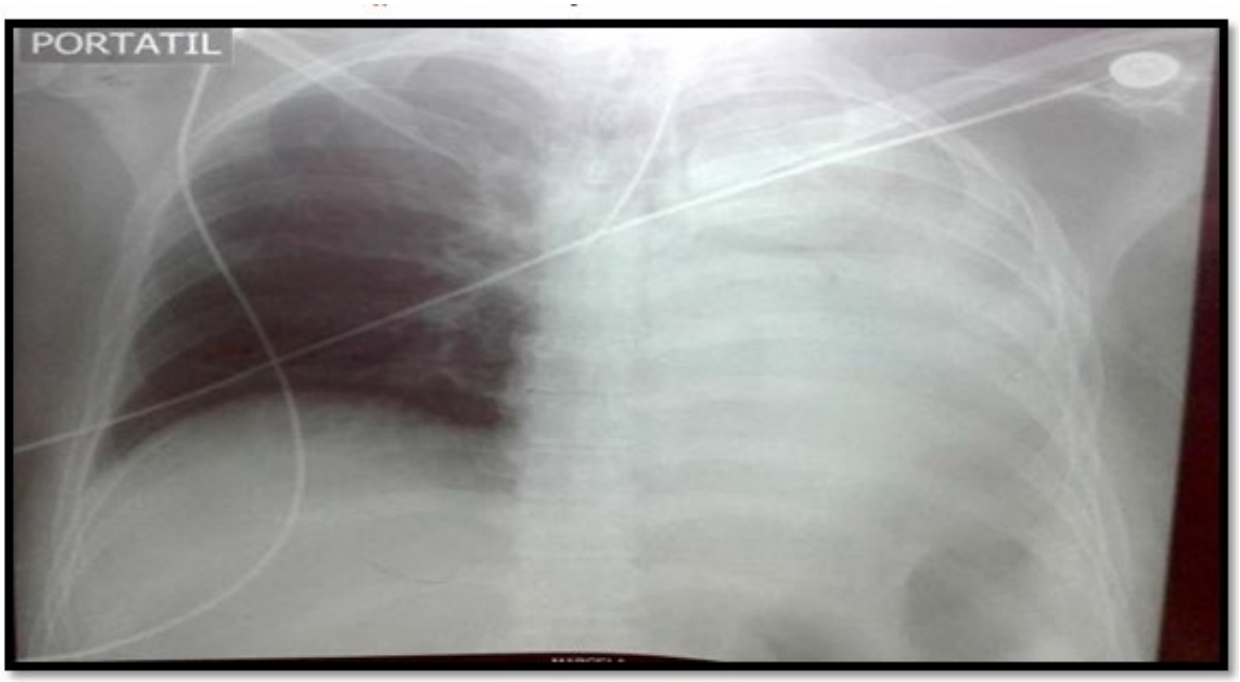
In Latin America there is scarcity of literature about the syndrome known as "the recommended patient" defined as the presence of unexpected or unusual complications in patients that their health team are trying to give a better assistance (1). In industrialized countries, it has been described as a related phenomenon known as VIP syndrome, this was first described in 1964 by Dr. Walter Weintraub at the Psychiatric hospital where he defined what VIP syndrome means, he found that the VIP patients were victims of the doctors who were trapped in this syndrome (2).

II. CASE REPORT

A 55-year-old woman with a history of recurrent gastritis was brought to the ER by his physician son for 8 hours of abdominal pain in right lower quadrant, associated to fever, nausea and four episodes of liquid stools. Vital signs were: blood pressure, 135/80 mmHg; heart rate, 95 beats/ minute; respiratory rate, 17 breaths/minute; oral temperature, 38,0˚C. At physical examination she had a soft and non-distended abdomen, with localized tenderness without guarding in the right lower quadrant, and a palpable painless mass in hypogastrium. Blood test results showed an elevated white blood cell count of 15,450u/L, hemoglobin 14,6g/dl and platelets 245mil/mm^3 Twenty minutes after the injection of contrast for an abdominal CT scan she developed, dyspnea, oppressive chest pain, and cyanosis. Her saturation dropped to 60% at a FiO2 of 21%. She was transferred immediately to a reanimation room and 2 L/min oxygen was administered through a facial mask. Then, received an injection of 1 mg of epinephrine and 200 mg of hydrocortisone and 50 mg of ranitidine. However, she did not improve, and she remained drowsy, about 10 minutes later she went to endotracheal intubation with a rapid sequence of intubation. She received 5 mg of midazolam (iv), 100 mcg of fentanyl (iv) and 30 mg rocuronium (iv). However, her saturation value did not improve, and her chest x-ray showed a left pulmonary collapse with a selective right bronchial intubation. Figure 1. The tube was relocated and five hours later she was Weaning from the ventilator.

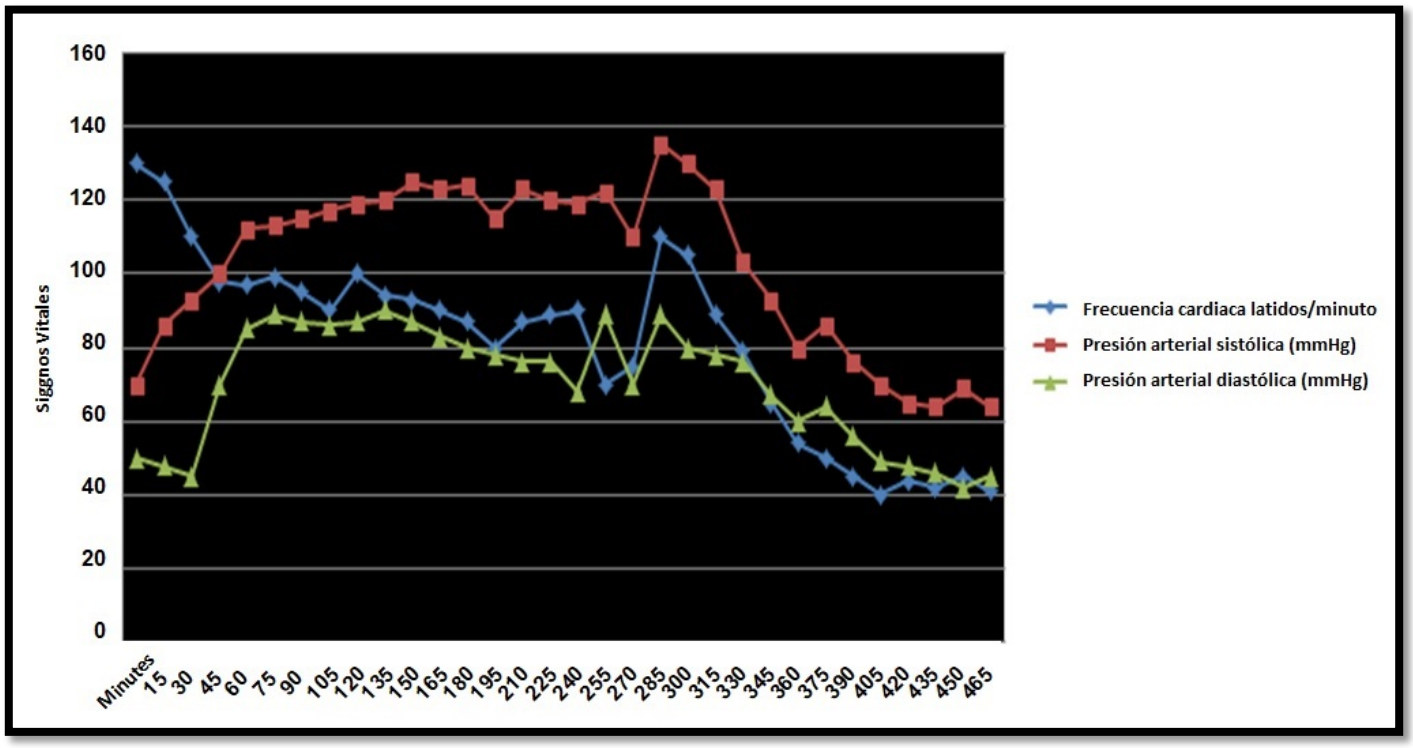
After removal the orotracheal tube the patient was alert. However, during the following 3 hours, she became sleepy but easily arousable. Also, bradipsychic, bradycardic and hypotensive (Graphic 1). Suddenly, she developed horizontal nystagmus, her pupils were miotic and had signs of respiratory depression. Her airway was secured once again, and all the monitors were checked. Her fentanyl infusion was running since her first attempt of removal orotracheal tube. It was suspected opioid toxidrome and 0,4mg of naloxone (iv) was administered. After 1 minute she responded and improved her neurological status. She was transferred to an intensive care unit, where she recovered satisfactorily. She remains in the wards during 7 days for an episode of acute diarrhea and no tolerance to oral intake. Later recovery she was discharge with no medications. At home, she experienced anxiety, insomnia and nightmares with visualization of what happened. She was diagnosed with post-traumatic stress syndrome and required clonazepam for 3 months to control her symptoms. Finally, she tapered the medication and did not required any other intervention. Table 1.

Figure 1: Chest-x-ray With Left Massive Atelectasis



Source: Courtesy from MCA.

Graphic 1: **Vitals Sings of a Patient With Fentanyl Toxicity**



Source: Data From e-health record.

Table 1: **Past Medical History**

PERSONAL HEALTH HISTORY	COMPLICATIONS BY CLINICAL CONDITION	CONDITIONS FOR BEING A VIP PATIENT	IN FAVOR OF VIP PATIENT
Personal: Married, Catholic, 2 child's, Professional Social Worker	No relationship	Family doctor	special treatment
Medical Conditions: Gastritis (2004)	None	Attention by the son´s colleagues	Unnecessary exams
Overweight (2000)	Difficult airway	Attention by the son´s colleagues	Fear to erring
abdominal wall eventration (2013)	Difficulty abdominal palpation.	Vigilance in resuscitation for your child	No follow the rules
Allergies: None	No relationship	removal of endotracheal tube	No follow the protocols
Medication: Esomeprazole 20 mg/day (2004)	No relationship	Infusion of fentanyl without control	Inadequate communication
Surgical history: C-section #1 (1987) C-section (1989)	Difficulty abdominal palpation	Prolonged hospitalization	Fear to erring
hysterectomy (2010), enterorrhaphy (2011)	Difficulty abdominal palpation		
Social: None	No relationship		
G/O: G2C2V2A0, Pomeroy, FUR 2010.	No relationship		
Family: Mom: Sotmach CA,	No relationship		
Dad: Lung CA and allergic to contrast material (1997).	No relationship		
allergic to contrast material (1997)	Genetic based		

Source: Data From e-health record.

III. DISCUSSION

The recommended patient syndrome presents itself as a series of medical complications that involve a patient who has an economic, social or family relationship with the doctors who treat him (1). In LA we found very few reports of this syndrome (1,4). In our knowledge there is no data of the frequency of this event in the emergency department even though, many people have a relative, friend or acquaintance who works in the health system and is susceptible of this occurrence.

Clinical manifestations

The VIP syndrome results when the process of care is not the regular by cause of the relationship between the physician and the patient. the unexpected complications are favored by a chain of mistakes, that start with an incomplete medical record, or perform the physical examination on inappropriate places or do an excess of diagnostic procedures which ends on unfortuitous complications.

Pathogeny

The medical decisions are made according to the findings found in the anamnesis and in the physical examination; Many times, the decisions are correct, however in this syndrome the final decision take a different path because there are no adequate conditions from the beginning of the encounter (4).

Sanz Rubiales et al suggest many causes for the appearance of this syndrome in clinical practice: a) Patients preferences for a prestigious physician. b) inadequate space and time for the consultation c) incomplete clinical records. d) Incomplete or excessive use of diagnostic tools. e) over treatment in a fashion of “better is more than less” (1).

Ethical aspects:

In addition to the VIP syndrome, the emergency room, is one of the first scenarios where the physicians have contact with VIP patients, they are called that because of the acronym in English that means "Very important people" who enjoy a social status and/or economic that privileges them and makes use of it to influence and modify the treatment they have in medical care (5). In other words, the benefits of care are based on a reduction of waiting time, personalized attention, special locations, care by the head of the department, treatments and unnecessary paraclinical (6). The VIP patient has 2 routes, the first one where the patient demands their treatment preferences to the institution, and the other, where the institution or the physician is the one who inadvertently provides sumptuous and preferential treatment, that in some cases ends with unfavorable outcomes for the patient (7).

To continue Illen Dicker describes there is a pressure associated with the care of these patients, close to 67% of the doctors exposed to the treatment and management of a VIP patient, said to feel an external pressure about the possible outcomes of their patient, and does not act according to the medical logic, In addition to this feeling, the study reported that 56% of the physicians agreed to the demands of the patients regardless of whether they were relevant to their treatment (8). This is where the ethical dilemma of the physicians begins, a struggle between their autonomy and what is justly correct, a struggle between what should be done and what the patient wants to be done. This triggers a loss of clinical objectivity (9). Many times, the physician´s desire to provide personalized and special treatment to their patients creates a dispute between medical autonomy and the principle of beneficence (10).

To avoid these mistakes, institutions and personnel in charge for the care of VIP patients must provide professional care based on ethical principles and science. Experts propose to array a portfolio of services based on nine principles, these nine principles can be summarized as follow: First, do not forget the usual rules and roles, work as a team, communicate well with the patient and your colleagues, manage media adequately, medical care shouldn’t be borrowed by the boss, always address conducts based on science and not on the patient's wishes, ensure patient care, never accept gifts and work only with staff of your institution and not with outsiders (11).

Our case 2: Our patient was admitted for abdominal pain, fever and diarrhea. The most common cause of this symptoms in our geographical area would be an acute diarrheal disease. Because the patient was related to a physician, they wanted to rule out a most serious pathology like appendicitis. The subsequent difficulties were not caused directly by the physicians. But nevertheless, the change of common practice guidelines facilitated the occurrence of those unusual complications.

IV. CONCLUSIONS

The VIP patient is the person who arrives at the health institution and enjoys a higher status, whether due to social, political, religious, economic or family ties with health personnel. This link or quality creates personalized attention. This is often reflected in unjustified and unnecessary exams and treatments; this may trigger non-objective attention with the appearance of inappropriate and biased behaviors, which cause an unfavorable outcome. This is where the recommended patient syndrome emerges. Yet until now there is no measured direct determinant that links a clinical attribute of the patient or his environment with the appearance of this syndrome. In conclusion, its appearance could be caused by an antecedent or direct clinical variable of the patient or by the special attention to which it is exposed. Studies are needed to determine the final etiology.

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Conflict of Interest: The authors declare no conflict of

interest.

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