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RESEARCH ARTICLE

PRISONERS FEIGNING BLOOD IN VOMITING- MALHOTRA BLEED

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ABSTRACT

Introduction: An upper gastrointestinal bleed (UGIB) in a prisoner can occur due to the same causes as in the general population, including peptic ulcers, oesophageal varices, Mallory-Weiss tears, gastritis, or even cancerous growths, but there are certain risk factors in prison like stress, poor diet, limited access to healthcare, and potential misuse of medications, leading to a higher likelihood of developing a bleed; for which prompt and early medical evaluation and treatment are crucial. The upper gastro-intestinal bleed is one of the most common indications for endoscopy. There are various reasons for the same and include gastric or duodenal ulcer, erosive gastritis or duodenitis, esophagitis, Mallory Weiss tear, gastric malignancy etc. Many prisoners feign to be having hematemesis but their history and clinical presentation does not match with it. **Aim of Study:** To determine the truthfulness of upper Gastrointestinal bleed in Prisoners who were referred from jails with complaint of blood vomiting and came for consultation in outdoor patient (OPD) of Medical Gastroenterology Department. **Materials and Methods:** It was prospective study done at PGIMS, Rohtak, over a period of almost five and half years from 01.10.2019 to 15.02.2025. In this duration, total seventy-five prisoners were referred from various jails with complaints of blood vomiting. Out of these seventy-five prisoners, five never gave consent for endoscopy and seventy underwent upper gastro-intestinal endoscopy. **Result:** The upper gastro-intestinal endoscopy in all the seventy prisoners was absolutely normal without any evidence of current bleed or recent bleeding stigmata and this false bleed has been termed as Malhotrableed in Prisoners.

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INTRODUCTION

Acute Gastrointestinal (GI) bleeding which is a life-threatening condition leads to frequent hospitalization (1,2). Any bleed originating from a source proximal to the ligament of Treitz is termed as upper gastro-intestinal bleed (UGIB) (3) and has incidence of roughly 100 cases per 100,000 population per year (4). It is four times more common than lower GI bleed and has overall mortality rate of 6%-10% (4). An upper gastrointestinal bleed (UGIB) in a prisoner can occur due to the same causes as in the general population, including peptic ulcers, oesophageal varices, Mallory-Weiss tears, gastritis, or even cancerous growths, but there are certain risk factors in prison like stress, poor diet, limited access to healthcare, and potential misuse of medications, leading to a higher likelihood of developing a bleed; for which prompt and early medical evaluation and treatment are crucial. The peptic ulcers are often related to Helicobacter pylori infection, excessive use of nonsteroidal anti-inflammatory drugs (NSAIDs), or stress in the prison environment whereas oesophageal varices can be associated with liver cirrhosis, a potential complication of heavy alcohol use. Mallory Weiss tears in the lower oesophagus are often caused by forceful vomiting, gastritis can be exacerbated by stress or medication use and cancer of upper gastro-intestinal tract are less common but still a possibility.

AIM OF STUDY

To determine the truthfulness of upper Gastrointestinal bleed in Prisoners who were referred from jails with complaints of blood vomiting and came for consultation in outdoor patient (OPD) of Medical Gastroenterology Department.

MATERIALS AND METHODS

It was prospective study done at PGIMS, Rohtak, over a period of almost five and half years from 01.10.2019 to 15.02.2025. In this duration, total seventy- five prisoners were referred from various jails with complaints of blood vomiting. All of them and underwent general physical and systemic examination, biochemical investigations like complete hemogram, liver & renal function test, viral screen, thyroid & lipid profile, urine complete examination, ultrasonogram abdomen, chest X-ray. Out of these seventy-five prisoners, five never gave consent for endoscopy and seventy underwent upper gastro-intestinal endoscopy.

STATISTICAL ANALYSIS: All the data was entered in Microsoft Excel and was analysed using SPSS 15.0 version.

RESULTS

Out of seventy-five prisoners, five never gave consent for endoscopy, thus they were excluded from the study and data pertaining to remaining seventy prisoners was analysed. All seventy prisoners who underwent endoscopy were males i.e. 100% and majority of them were illiterate, belonged to poor socio-economic status and resided in villages i.e. 59 patients (84.28%). In total pool of 70 prisoners, there was predominance of young males and maximum belonged to 18-30 yrs of age group i.e. 57 (81.42%) and rest 13 patients (18.58%) were between 31-40 yrs of age group. All of these 70 patients had no co-morbid illness and gave history of recent onset of blood vomiting which has never occurred before they joined the jail. All of these 70 patients came for consultation in outdoor department, walking on their own and had no hemodynamic compromise. Out of 70 prisoners, 60 (85.71%) gave history of fresh red coloured blood in vomiting and rest 10 (14.29%) gave dark coloured blood in vomiting. The detailed physical and systemic examination was normal in all seventy patients. There were no symptoms or sign of chronic liver disease in anyone. The classical thing was nobody gave history of melena. No abnormality was detected in the bio-chemical tests and X-ray of all the prisoners. The ultrasonogram showed fatty liver in ten patients and in rest sixty, it was absolutely normal. The endoscopic findings in all the seventy prisoners were classically and absolutely normal without any evidence of current bleed or stigmata of recent bleed, meaning by there were no erosions, ulcer, duodenal, gastric or ectopic varices, esophagitis or gastric antral vascular ectasia.

Table 1. Showing Sex and Age distribution in Prisoners who underwent Endoscopy

Prisoners who underwent Endoscopy	Male	Female	18-30 yrs Age group	31-40 yrs Age group
70 (100%)	70 (100%)	0 (0%)	57 (81.42%)	13 (18.58%)

Table 2. Showing Endoscopy Findings in Prisoners

Total Prisoners in whom Endoscopy was done	Prisoners with Normal Endoscopy	Prisoners with Abnormal Endoscopy
70 (100%)	70 (100%)	0 (0%)

DISCUSSION

There is almost negligible literature on UGIB in prisoners, the WHO has given guidelines on various health issues of prisoners, including physical and mental illnesses but UGIB is missing (5). There is one another small study done by our group on UGIB in prisoners (6) which prompted us to continue to follow prisoners coming with complaints of UGIB. The Comorbid illnesses are commonly seen in UGIB and can be the primary cause of death (7,8) but in our study group of 70 patients, none of them had any co-morbid illness. The UGIB is seen more commonly in men and its prevalence increases with age (>60 y). However, the death rate is similar in both sexes (8,9). In our pool of 70 patients, all were male. In a study on UGIB, the all-cause 30-day readmission rate was 14.6% (vs. 14.4% for LGIB) (10) and most common causes were GI disease, cardiac, infectious and respiratory. In our study group, none of the patient reported with re-bleeding. The UGIB causes significant mortality rate but in our pool, as expected in view of haemodynamically stability and normal endoscopy, there was no mortality. The history and physical examination are important in the initial evaluation of UGIB and stresses on Comorbid conditions, medication history, and any prior history of GI bleeding, as well as the severity, timing, duration, and volume of the bleeding (3). History findings include weakness, dizziness, syncope associated with hematemesis and melena and gives rough measure of total blood loss. In our study group every patient gave history of hematemesis but none has melena. Many prisoners even exaggerated the amount of blood lost in vomiting by explaining that whole floor was soaked in blood. The clinical examination and investigations were characteristically normal in all 70 prisoners. The alarming signs and symptoms of hemodynamic compromise include tachycardia of more than 100 beats per minute, systolic blood pressure of less than 90 mm Hg, cool extremities, syncope, and other obvious signs of shock, ongoing brisk hematemesis, or the occurrence of maroon or bright-red stools, which requires rapid blood transfusion but none of above parameters were deranged in anyone of 70 prisoners. The reality is that all these 70 prisoners in our pool were intentionally giving total false history of blood vomiting with sole purpose of getting medical documents prepared for getting bail or for visiting hospital for outing purpose and meeting family members in hospital, getting chance to sneak drugs into jail or even flee from the police custody during hospital visit. This false bleed, as alleged by prisoners has been termed as MALHOTRA BLEED. These all facts were brought up by few prisoners in our group, after persistent convincing and assurance of not being shared with anyone. Some prisoners were fed by their legal team and rest also imbibed the same idea. All of them never knew that once hematemesis is there and in majority of patients melena will occur and can lead to hemodynamic compromise. They had no idea that blood vomiting is usually black coloured and not fresh red colour. There has to be some aetiology for UGIB which is reflected on investigations including endoscopy. They concocted story of blood vomiting, as jail doctor can be easily convinced for referring them to higher centre for further evaluation and endoscopy. Out of total 75 patients, five patients even refused for endoscopy either they never knew that they will be subjected for this invasive procedure or due to fear of being caught for their false story of UGIB. All these five patients also were brought in a normal condition, walking comfortably on their own, belonging to younger age group, without any co-morbid illness. The initial group of patients stimulated us to closely follow all the future prisoners with iota of doubt for genuineness of their hematemesis complaint. Our doubt was confirmed, once we were able to confirm endoscopy findings in all of them. Our team also has experience for last 14 years of doing emergency endoscopies for UGIB, including for prisoners. In that scenario, majority of patients including prisoner were found to be having clear cut aetiology for UGIB. In some where no finding was seen, in majority of them, it was haemoptysis which was wrongly interpreted as hematemesis. We as a treating team give psychotherapy to all these prisoners, that by lying, they will have no advantage but it will be reverse because, all of them were evaluated in detail and it was labelled that they are totally healthy. No prisoner in our study group reported back with rebleed, may be due to psychotherapy or fear of repeat endoscopy, need of which was clearly explained to all of them, at time of first endoscopy, with a view to act as a deterrent for repeat false complaint of UGIB in future. We on our level, informed the jail authorities including treating doctor

also, so that proper evaluation of prisoner can be done in UGIB, before referring for endoscopy.

CONCLUSION

Prisoners usually have criminal bent of mind and they can be easily trained by their legal team for feigning health issues which can help in getting out of jail on temporary or permanent basis. The prisoners can even try to influence the jail authorities including doctors posted in jail, for referring them to outside jail to bigger hospitals for consultation and endoscopy. Normally, majority of basic ailments of prisoners are treated in jail by doctors posted there and prisoners can be referred outside the jail only when they have to feign that disease which cannot be treated at jail, like UGIB. Thus, there is strong need to train the duty doctors in jails about UGIB, so that wrong and fake bleed reported by prisoners can be sorted at level of prisons only. Once, this starts happening and these prisoners with pseudo bleed are not rightly referred from jail, then this chain will break in other prisoners also. The rare phenomenon rarely occurs but do occur but experience gained regarding feigning of bleed in prisoners, by our team over prolonged period of almost five and half years, prompted to name this entity as MALHOTRA BLEED. The factor which helped us that as our department is sole government set up with endoscopy facility, thus all of them were referred to us for endoscopy. After few initial cases, we already had doubt, thus these prisoners were being closely observed for pattern of their complaint of UGIB. The crux of matter is that experience of health professional depends upon the number of patients treated and every complaint is important, true or false.

LIMITATION OF STUDY

In the present study, there was limited number of prisoners who reported in emergency department, even at odd hours, in comparison to our study group of seventy prisoners who all were haemodynamically stable and reported in routine hours, in outdoor patient department.

CONFLICT OF INTEREST: The authors declare that there was no conflict of interest and no funding from any source was taken.

REFERENCES

1. Curdia-Goncalves T, Rosa B, Cotter J. New insights on an oldmedical emergency: Non-portal hypertension related upper gastrointestinal bleeding. Rev ESP Enferm Dig. 2016; 108: 648-656.
2. Lirio RA. Management of upper gastrointestinal bleeding in children: Variceal and nonvariceal. Gastrointest Endosc Clin N Am.2016; 26: 63-73.
3. Fallah MA, Prakash C, Edmundowicz S. Acute gastrointestinalbleeding. Med Clin North Am. 2000; 84: 1183-1208.
4. Pongprasobchai S, Nimitvilai S, Chasawat J, Manatsathit S. Upper gastrointestinal bleeding aetiology score for predicting variceal and non-variceal bleeding. World J Gastroenterol. 2009; 15:1099-1104.
5. Stefan Enggist, Lars Møller, Gauden Galea, Caroline Udesen. Prisons and Health. WHO guidelines.2014.
6. Pseudo Upper GI Bleed in Prisoners**.** Malhotra P, Sanwariya Y, Vohra M, Lakshay, Shalini, et al. J Clin Images Med Case Rep. 2022; 3(12): 2210.
7. Yavorski RT, Wong RK, Maydonovitch C, Battin LS, et al. Analysis of 3,294 cases of upper gastrointestinal bleeding in militarymedical facilities. Am J Gastroenterol. 1995; 90: 568-577.
8. Stabile BE, Stamos MJ. Surgical management of gastrointestinalbleeding. Gastroenterol Clin North Am. 2000; 29: 189-222.
9. Jairath V, Desborough MJ. Modern-day management of uppergastrointestinal haemorrhage. Transfus Med. 2015; 25: 351-357.
10. Peter DJ, Dougherty JM. Evaluation of the patient with gastrointestinal bleeding: An evidence-based approach. Emerg Med ClinNorth Am. 1999; 17: 239-261.

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