

Video Abstracts

Nine Years with Munchausen Syndrome: A Case of Psychogenic Dystonia

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Abstract

Background: Munchausen syndrome presenting with psychogenic dystonia is a rare condition.**Phenomenology Shown:** A psychogenic dystonia case presenting with an acute onset of retrocollis, lower limb dystonia and bizarre gait was diagnosed as Munchausen syndrome.**Educational Value:** Recognizing psychogenic dystonia avoids unnecessary investigations and provides successful treatment.**Keywords:** Factitious disorder, psychogenic movement disorder, dystonia.**Citation:** Cakmak MA, Sahin S, Cinar N, et al. Nine years with Munchausen syndrome: A case of psychogenic dystonia. Tremor Other Hyperkinet Mov. 2015; 5. doi: 10.7916/D8ST7NS8*To whom correspondence should be addressed. E-mail: drsahin@gmail.com**Editor:** Elan D. Louis, Yale University, USA**Received:** January 2, 2015 **Accepted:** April 23, 2015 **Published:** June 8, 2015**Copyright:** © 2015 Cakmak et al. This is an open-access article distributed under the terms of the Creative Commons Attribution–Noncommercial–No Derivatives License, which permits the user to copy, distribute, and transmit the work provided that the original author(s) and source are credited; that no commercial use is made of the work; and that the work is not altered or transformed.**Funding:** None.**Financial Disclosures:** None.**Conflict of Interest:** The authors report no conflict of interest.

Herein, we report the case of a 27-year-old female with hemifacial spasm (HFS) who was treated at another neurology clinic for 9 years and finally diagnosed with Munchausen syndrome by us.

Nine years prior, at the age of 18, she was diagnosed with HFS by a neurologist. Detailed records of prior treatment were not available; however, she reported that only botulinum neurotoxin treatment (BoNT) had been effective for her HFS. She had seen the previous neurologist regularly every 3 months and had developed friendships with other patients there.

She was admitted to our clinic for acute onset of retrocollis, left-lower-limb dystonia and gait disturbance. Video Segment 1 shows the initial evaluation of the patient. Movements are markedly diminished in amplitude and intensity. Retrocollis, bizarre upper extremity posture, dysarthria and flexion posture during walk have been observed. Routine blood examinations, cerebrospinal fluid analyses, serum paraneoplastic markers, ceruloplasmin, and serum and urine copper were found to be within normal limits. Brain magnetic resonance imaging and electroencephalographic analyses were normal. She did not respond to an L-dopa test. Tetrabenazine was started at a dose of 25 mg/day and gradually increased to 75 mg/day. She rejected this drug because of nausea and insisted on BoNT therapy. Abrupt onset and distractibility of her

symptoms, fast progression to severe disability, and bizarre and unclassified gait disturbance made us suspect psychogenic movement disorder (PMD). We interviewed her family and received information regarding a precipitating event (a slap to the affected side of her face) before the onset of HFS, 9 years previously. She had recently argued with her husband about moving to a new house before the onset of the new acute symptoms.

We applied a placebo BoNT (physiologic saline-0.9% NaCl) injection to her neck and facial area and over a period of 7 days this was followed by a great improvement in all symptoms including HFS, retrocollis, and gait disturbance. Video Segment 2 shows the patient after placebo treatment. There are no abnormal findings. She was informed about the placebo response and PMD diagnosis. She initially accepted the PMD diagnosis and psychiatric consulting. However, in her second interview with her therapist, she rejected her diagnosis and cancelled therapy.

Although this diagnosis is easily underestimated in outpatient clinics, PMD patients are thought to account for 2–3% of all patients in movement disorder clinics. The psychiatric diagnoses given to PMD patients include conversion disorder (75%), somatization disorder (12.5%), factitious disorder (8%), and malingering (4%).¹

The signs of PMD are abrupt onset of symptoms, unusual neurological involvement, presence of secondary gain, female gender,



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difficult to classify bizarre movements, unresponsiveness to appropriate medications, and response to placebo.² Our patient was gaining various benefits from her family, including attention, sympathy, and support for her strong desire to move to a new house. It is possible she developed some features of her illness by learning from other patients.

Our patient was diagnosed with factitious disorder according to The diagnostic and statistical manual of mental disorders, 5th ed. Patients with factitious disorder may simulate a disease to draw attention to themselves, and to receive sympathy or reassurance.² In his 1951 article, Richard Asher named this condition Munchausen's syndrome after "Baron Munchausen" (a fictional character who tells many fantastic and impossible stories about himself). This term is still used for the most severe form, where the simulation of disease is the central activity of the affected person's life.³

Identifying PMDs can be a challenging task in neurological practice. If PMD is suspected, there should be an initial psychiatric examination followed by detailed family interviews. Physicians should always be aware of possible PMD for successful diagnosis and treatment.

References

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