A Case Report of Munchausen Syndrome.

Obote W W MMed (Surg) FCS (ECSA).
Kakande I MMed (Surg). FCS (ECSA)
Olaro C MMed (Surg), FCS(ECSA).
Dept of surgery, Makerere University.

Correspondence to: Dr. Obote W W, Department of Surgery, Makerere University, P O Box 7072, Kampala, Uganda.

We report a case of a 31-year old female patient who presented to Mulago Hospital with symptoms suggestive of intestinal obstruction and gave a complicated past history which included thirteen previous operations in seven different hospitals over a period of about twelve years. She underwent a laparotomy at which no intestinal obstuction was found.In retrospect we diagnosed her as suffering from the rare Munchausen syndrome. The paper discusses the characteristic clinical features, differential diagnoses and management of this interesting syndrome.

Introduction

Factitious disorders are characterized by the willful production of physical and / or psychological symptoms and signs for no apparent goal. This is best exemplified by Munchausen syndrome[1] a term coined by Asher[2] to describe a disorder observed in patients who traveled widely (peregrination) in England, presenting at various health units with simulated medical illnesses, and pathological lies (pseudopodia fantastica)[3]. He observed that these patients often told elaborate tales in an entertaining manner and therefore named the syndrome after Baron von Munchausen, an 18th century German soldier and raconteur known for his tall tales[4,5]. In this review we present a case of Munchausen syndrome we encountered in Mulago Hospital, in Uganda.

Case report

A.M., a 31 year-old female presented to Mulago Hospital Casualty unit during one night in January 1997 with a two days history of severe abdominal pain, vomiting and absolute constipation. She demanded urgent operation to relieve her symptoms.

She gave a complicated past history that started with an appendectomy in 1984. This was followed by fourteen laparotomies in six different hospitals. She was found to have a fairly good knowledge of medical terminology and the procedures she had undergone but could not produce medical documents to substantiate her claims. Table1 gives a summary of the hospitals attended and the operations performed

Social History

She had worked as an auxiliary nurse before she entered a nursing school. But for unclear reasons she did not complete her course. She was nulliparous and single. She denied any history of alcohol consumption or smoking.

Findings on Physical, Radiological and Laboratory examinations

She was found to be a young lady in satisfactory general condition. Per abdominal, She had multiple abdominal scars. The abdomen was markedly tender and the bowel sounds were reduced. Vaginal and rectal examinations were normal. Plain abdominal radiographs showed gas in the small bowel and in the rectum. Other investigations done (or repeated) included; Hb electrophoresis, porphobilinogen in urine and blood glucose tests which were all normal

A conservative approach was first adopted but this was later abandoned in the night when her systolic BP dropped below 100mmHg. At laparotomy, extensive adhesions were found but there were no features of bowel obstruction

Postoperative Management

Postoperatively, the patient continued to complain of severe abdominal pain for which large doses of narcotics were prescribed. By the 10th post operative day she still complained of abdominal pain, nausea and vomiting and would go into lapses of altered levels of consciousness. She was however heamodynamically stable.

She was eventually discharged after about a month in hospital only to find her way to Kenyatta National Hospital in Nairobi, Kenya where she underwent another laparotomy

Table 1. Details of hospitals attended and operations done as given by the Patient

Hospital	Year	Operation done
Nsambya	1984	Appendectomy
	1987	Ovarian cystectomy
Rubaga	1989	Ectopic pregnancy
	1990	Intestinal obstruction
	1991	Adhesiolysis
Tororo	1992	Bowel resection & anastomosis
Nsambya	1992 (August)	Adhesiolysis
	1992 (December)	Adhesiolysis
Mulago	1993	Ovarian cystectomy
Kibuli	1994	Adhesiolysis
Mulago	1994	Adhesiolysis
	1995	Adhesiolysis
	1996	? Ovarian tumour

Psychiatric Workup

A consultant psychiatrist was consulted for a psychiatric assessment. The following facts were noted:

- The patient had had 15 operations in 14 years for similar presentations though different diagnoses had been made and included appendicitis, ovarian cyst, ectopic pregnancy, ovarian tumour, adhesions and multiple bowel obstruction.
- She was of sound mind but evoked feelings of futility, bewilderment, betrayal and hostility.
- She had a habit of moving from hospital to hospital requesting for surgery.
- No friend or relative ever visited her in hospital.

This time no surgery was done. She discharged herself from the hospital. Later in the year she put up an advertisement in the Government Newspaper soliciting for funds to go for treatment in U.S.A for intestinal obstruction!

Discussion

The true incidence of Munchausen syndrome is unknown and in its extreme form is relatively rare. It frequently affects men of lower socioeconomic classes with a history of social maladjustment[4].

Women of medically related training have also been known to be affected[5] as exemplified by this lady. Other authors have reported equal distribution in both males and females[7]

Tables 2 and 3 show the characteristic features reported in Munchausen syndrome. There may be a history of predisposing psychological disorder during childhood or adolescence such as deprivation and rejection[8]. Associated features may include significant signs of personality disorder, such as dependence, exploitativeness or self-defeating behaviour. Acute object loss such as loss of a family member or loss of a job may be a predisposing factor[9]. These patients have a history of repeated hospitalization. Any organ system may serve as a site of pain[5]. Laboratory abnormalities have been detected such as anaemia, hypokalaemia, hypoglyceamia and coagulopathies[5].

Table 2. Characteristics features of Munchausen Syndrome Present in **A.M**

Characteristic	Present
Acute presentation	+
Dramatic symptoms	+
Lack of steady employment	+
Visible evidence of previous surgery (multiple abdominal scars)	+
Lack of visitors	+
Personality disorder(s) with absence of major psychiatric illness	+
Medical sophistication (unusual grasp of medical terminology)	+
Previous care givers difficult to contact	+
Consuming desire for medical / surgical care	+

+ =Present in case under review

Table 3. Characteristic features reported in Munchausen syndrome

Characteristic Feature	Present
Shifting complaints	-
Late arrival in emergency units	+
Peregrination (ravel from city to city, from hospital to hospital)	+
Denial of previous surgery / medical history	-
Demand for medication / tendency to quarrel with staff	+
Predisposing physical illness	?

+ = Present in case A.M. - = Absent ?= uncertain

Known Mechanism for gaining admission reported include:

(a) Deception – Feign illnesses.
(b) Laparotomaphilia- hope for laparotomy.
(c) Heamorrhagica histrionica- alarming bleeding.
(d) Neurologica diabolica- curious fits.
(e) Cardiopathia fantastica- false heart attacks.
The first two were noted in this patient.

It must be remembered that factitious disorders are not real or genuine physical illnesses[7] .They are feigned or induced.

The common illnesses induced or feigned are:

- bleeding tendencies,
- G.I symptoms,
- skin lesions including wounds,
- infections,
- cancer.
- HIV, and necrotising fascitis have all been reported[9,10,11].

Differential Diagnosis

1. Malingering –here there is a goal such as avoiding prosecution.

2. Somatoform disorders-differentiated from factitious disorders, which have voluntary production of symptoms.
3. Antisocial personality disorder – Lack of close relationship with others, hostile manipulative manner.
4. Hysterical (histrionic) personality- attention seeking and a flair for the dramatic.
5. Schizophrenia
6. Drug abuse-May be a co-existing diagnosis, because of exposure to a complex number of drugs.
7. Hypochondrias
8. Undiagnosed medical and surgical conditions.

Management

Thorough investigation is first needed to exclude all medically and surgically treatable conditions before a diagnosis can be made.

The most trying time is the period prior to diagnosis. The patient should be recognized as sick. Early psychiatric help is useful. It should be remembered that many patients have some medical training (e.g. a nurse, lab technician, and doctors)[1,2,13]. Patients consider themselves and their illnesses to be important and the physician is perceived as a potential source of comfort and love and as a person who will fulfill their unmet dependency need[1,2].

They may resist psychiatric intervention overtly or with covert passivity and negativity. Suffering should be acknowledged but patients should not be encouraged in their fixed beliefs about their illness. Any sign of healthy adaptation should be encouraged. In addition attempts should be made to see the patient in an outpatient setting regularly on non-symptom linked schedules.

Family members should be involved and attempts should be made to identify as many supportive avenues as possible[6]. A course of chronic hospitalization is incompatible with meaningful vocational work and sustained interpersonal relationship[1,2]. As Hippocrates stated," It is more important to know what kind of a person has the disease than what kind of disease the person has."

Treatment is rarely successful, prognosis being poor, but attempts to initiate therapy should always be made[6]

Conclusion

Awareness of the diagnostic criteria for Munchausen syndrome and the many modes of its presentations are important for all physicians and surgeons. However the problem that may arise is that a patient with a genuine physical problem may be over looked or misdiagnosed. This may lead to an unfavorable management outcome. All doctors who deal with emergencies should be aware of this syndrome, alert to it and carry out very careful evaluation every time they suspect it.

Caution! It would be most unfortunate for a surgeon to think of Munchausen syndrome as a first diagnosis. This may lead to the missing of an important diagnosis[9].

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