Munchausen's Syndrome - More Common Than We Realise?

AM Doherty, JD Sheehan
Department of Adult Psychiatry, UCD/ Mater Misericordiae University Hospital, 63 Eccles St, Dublin 7

Abstract
Munchausen's syndrome is a condition whereby a patient deliberately simulates symptoms of an illness in order to gain admission to hospital and gain the sick role. It is an uncommon condition and is possibly underdiagnosed. This case-series examines the cases of three patients with Munchausen syndrome who presented to a Dublin hospital within a four-month period. Two of the presentations involved the feigning of psychiatric symptoms. It is important that clinicians not only in psychiatry, but in all medical specialties have an awareness of this disorder, so that unnecessary procedures and treatments may be avoided.

Introduction
In Munchausen syndrome or factitious disorder, the affected person exaggerates or creates symptoms of illnesses in themselves in order to gain investigation, treatment, attention, sympathy, and comfort from medical personnel. The term was coined by Asher in 1951, with reference to Baron von Munchausen, a legendary teller of tall tales. Typically, such patients have a history of repeated feigned or simulated illness, pseudologia fantastica (pathological lying) and peregrination (travelling or wandering from hospital to hospital). Patients with Munchausen's syndrome may have other features, including an unusual or dramatic presentation, equanimity for diagnostic procedures, treatments or operations, evidence of self-induced physical signs, multiple scars and multiple hospitalisations. They may simulate various illnesses in various systems, including fever, skin infections, anaemia, asthma, Cushings disease, phaeochromocytoma and even cancer. They are often admitted through an Emergency department, sometimes under an alias. Psychiatry, with the dependence of the clinician on the patients history, is a particularly difficult specialty in which to detect factitious disorders. In this case series we describe three cases of Munchausens syndrome which presented to the Liaison Psychiatry service of a Dublin hospital, two of which involved feigned psychiatric symptoms.

Case 1
In April 2003, a patient with global amnesia was admitted to the Psychiatric unit from the Emergency Department. In trying to identify the patient, the media had publicised his story and printed his picture. Interpol were involved. Two weeks later another patient, F.B. presented to the Emergency Department via a local police station. He complained of global amnesia. He did not know his name, address or occupation. Mental state examination showed a casually dressed man with poor hygiene. His speech was normal and his mood euthymic. There were no symptoms of psychosis elicited and no evidence of cognitive impairment. He was admitted to the psychiatric unit. After three days a telephone number was found on his person, this transpired to be his fathers number. He said F.B. was in the habit of going from hospital to hospital and that he was currently on the waiting list for admission to his local psychiatric hospital because of paranoid schizophrenia. He was discharged with a diagnosis of Munchausen Syndrome.

Case 1a
M.C. was admitted to the orthopaedic ward with multiple fractures having fallen from scaffolding in late 2007. Two weeks later, his treating orthopaedic team sought a psychiatric consultation querying paranoid ideation. On interview, he described well-circumscribed delusions of persecution and passivity. He denied hallucinations in any modality. His affect was congruent and his mood euthymic. He gave a past psychiatric history of post-traumatic stress disorder and depression, asserting that he had a two-day psychiatric admission twenty years previously. Furthermore, he had a family history of elation. He said he had been living with his mother prior to admission, but that he could not return to this house. A CT brain requested was normal. He was commenced on 10mg of Olanzapine, and his psychotic symptoms resolved within 3 days. A referral was sent for follow-up to his local mental health service, which conflated with his mother, and said that he had been lying. A local practitioner did not know the patient and the next of kin given was uncontactable. The patient made unconvincing excuses for these. He was referred to the homeless services on discharge.

After discharge, it was realised that MC was in fact an alias for PB as described in Case 1. It was then discovered that PB had eight aliases in the hospital, giving slightly different personal details and histories on each admission. He was being treated by his local psychiatric service for paranoid schizophrenia for the preceding 12 years. Several weeks later, he presented at the outpatients department without an appointment, saying he was homeless and seeking accommodation. On mental state examination there was no evidence of any psychopathology. The following day he was admitted to his local psychiatric hospital, describing symptoms of acute psychosis, having been caught breaking into a house.

Case 2
I.B. a 40-year-old male presented to the Emergency Department with police and the presenting complaint: I have no memory. He claimed to have travelled by boat from Holyhead, Wakes to Dublin Port, and then presented himself to a nearby police station complaining of amnesia. As in Case 1, one week previously a patient with global amnesia had presented to the same police station, with global amnesia. Her case had been widely reported in the media as police attempted to ascertain her identity. On interview, I.B. initially claimed to be amnesic, but after a short while the inconsistencies in his story became more apparent, he admitted that he had fabricated his story: I have been lying, I've got amnesia. He admitted to being an inpatient for the past year in a psychiatric hospital in the UK with a diagnosis of treatment resistant schizophrenia. He described what he termed delusions, saying: I have delusions about Andrea Corr, but did not seem convincing. He also claimed: I was coming here to become God. When asked if he fabricated this delusion, he said: Thats for the doctors to decide. On mental state examination his speech was normal, his affect congruent and his mood euthymic. He described delusions, as above but there was no evidence of any other psychotic symptoms. He was cognitively intact.

He described a fifteen-year history of schizophrenia, currently treated with clozapine. He was due to be imminently discharged from the secure psychiatric unit where he had been an inpatient for one year. Collateral obtained from patients treating hospital confirmed his diagnosis, medications, that he was currently an inpatient and had absconded the previous day. They reported that he had travelled to Ireland in a similar fashion previously. A diagnosis of Munchausen syndrome was made, and I.B. was repatriated.

Case 3
P.O.R. a 49-year-old woman was referred from the breast clinic for a psychiatric opinion; she had requested a prophylactic bilateral mastectomy. She stated her 4 sisters had died before age sixty, all from breast cancer. One aunt had died aged 67 from breast cancer. She met the criteria for capacity to consent to treatment. There was no...
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Collateral obtained from her general practitioner indicated she had not attended him for more than one year. Although she had been carried out largely at the patient's request. When "POR" was confronted with the above facts, she became upset and irritable. She claimed that her sister who died of Hodgkin's disease was a stepsister. She was told that she had a diagnosis of Munchausen's syndrome. She again refused to consent to her next of kin being contacted. She did not attend any further appointments.

In Cases 1 and 2, there are a number of marked similarities. Each patient had simulated amnesia after media reports of global amnesia. They both also simulated symptoms of schizophrenia convincingly. In Case 1, the patient had been treated for schizophrenia by his local psychiatric service for several years, but in his second presentation described in Case 1a above, he denied any such history. In Case 2, the patient had been treated for schizophrenia for several years. As his symptoms did not improve on medications he was considered to be treatment-resistant. Case 1a gives an example of how psychiatry may be abused in order to seek exemption from the normal rigours of the law. In the incident described, where the patient described dramatic psychotic symptoms having been caught in the act of burglary, he took the step from Munchausen's into frank malingering, in changing his objective from secondary gain to primary gain. Munchausen's syndrome has been associated with elective mastectomies, and it is the practise in many countries for a patient to have a psychiatric assessment as part of the pre-operative work-up. Case 3 is typical in her history of a deprived childhood and her background in the healthcare profession.

The aetiology of factitious disorder is not wholly understood, but unconscious motives, developmental or family factors, life stressors, psychodynamic mechanisms such as mastery, masochism and dependency are thought to play a role. Its management involves recognising the diagnosis and addressing the issue with the patient in a non-punitive manner, allowing them to find an honourable way out. Although previously confrontation was thought to be unhelpful, new evidence suggests that it may be helpful in offering the patient an interpretation of his/her behaviour. It is also important to protect the patient from iatrogenic risk.

References