MUNCHAUSEN SYNDROME NOT AN UNCOMMON CONDITION

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INTRODUCTION

Every doctor in his life encounters two or three patients whose entire existence is devoted to obtain hospital admission by an accurate simulation or exaggeration of their symptoms. There are individuals who are misusing the hospitals since the hospitals have existed for the collective care of patients. Medical literature from many countries is full of stories of such adventurous persons. This condition remained nameless until Asher [1,2] in 1951 described a group of such patients who, like the famous Baron Von Munchausen have always traveled widely and their stories like those attributed to him were both dramatic and untruthful'. This fictitious disorder occurs mainly in early adult life, is more among men and is usually encountered in a dramatic manner in the emergency department. These patients have a history of repeated hospitalizations extending over years so that they seem to have adopted the role of patient as a career. There is gross lying (pseudologia fantastica), which comprises of giving false medical histories and false names. They may interfere with the diagnostic investigations and may obstruct the efforts to obtain information about their illness. They invariably discharge themselves from the ward prematurely. The etiology and long-term outcome are unknown [3]. Following case reports are intended to further highlight this subject.

CASE REPORTS

Case – 1

A 52 years old unmarried, ex-serviceman, living with his brother presented with small paraumblical hernia for which Mayo's repair was done. He requested for discharge on 4th postoperative day due to some emergency at home and was thus discharged on request. He did not report for follow up subsequently. After three months he reported back with recurrence of hernia. Mesh repair was done. During convalescence, his wound got infected superficially and few scratch marks were noticed around the wound. During his stay in hospital he started making allegations on ward staff and junior doctors regarding their behavior and efficiency. He asked for discharge many times by giving certain domestic reasons but he was sent home after complete recovery. He again did not report for follow up during postoperative period. After about six months he reported to some senior non-medical official whom he narrated his history in a dramatic way, who sent him to hospital for admission. This time his recurrence was large with a wide defect in abdominal wall. Superficial ulcers and scratch marks were found over the skin. He was admitted and complete assessment for the cause of recurrence was done but no etiologic or aggravating factors were found. According to his brother, he often remained absent from home for days and roamed purposelessly here and there. The senior surgeon did Mesh repair of hernia. He was kept under close observation postoperatively for about six weeks in hospital. During his stay in hospital he repeatedly asked for discharge, made allegations on ward staff and refused to take treatment. He developed superficial ulcers over the operated area. On examination scratch marks were found around the ulcers. He was kept under surveillance and it was revealed that he used to scratch intentionally and create these ulcers over the skin. On discharge he was handed over to his brother and complete counseling was done regarding his illness. After discharge he again

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disappeared and never reported for follow up. After about five months, he was again admitted in some other local hospital in emergency due to wound infection, constipation, and multiple other complaints. He was shifted to our hospital for further treatment. During his stay he repeatedly insisted for surgery and made suicidal threats when surgery was refused. A board was assembled comprising of psychiatrist, medical specialist, and plastic surgeon and senior general surgeon for the evaluation of this patient. The board concluded that he was a case of "Munchausen's syndrome". For last 4 years he had 20 hospital admissions and countless outpatient consultations mostly with excoriation after scratching thin skin.

Case – 2

This 36 years old male was admitted in emergency due to bleeding from wound over right inguinal region. According to the patient he was operated for right inguinal hernia three years back and since then he had bleeding from the wound off and on. On clinical examination there was a wound over right inguinal region, which was 4×2 cm wide and about 2 cm deep. Small ooze from the wound was noticed with dressing and no signs of infection were found. Wound was clean with reddish floor and edges and without granulation tissue. No active bleeding point was found. Patient was anxious, tense and in misery. He repeatedly accused the previous doctors and staff who treated him. He had complete medical record with him. He had Bassinie's repair of his right inguinal hernia three years back and got discharged himself on request after three days. Then he was admitted after 2 months with wound infection in some other secondary care hospital. Then he had multiple hospitalizations due to bleeding and infection from the wound in various hospitals. His wound exploration was also attempted twice by different surgeons for any bleeding point but no cause was found. He was admitted and after complete evaluation and observation no cause was found. He was kept under surveillance, repeated dressing was done but he had persistent soakage of dressing especially over night. On careful examination few scratch marks were found over the margins and around the wound. His right index finger nail was of large size and blood was deposited under the nail. On further inquiry patient confessed that he used to scratch his wound with his nail to bleed and get admission in hospital.

DISCUSSION

Fictitious disorder with predominantly physical signs and symptoms has been designated by a variety of labels the best known among them being Munchausen syndrome. It is named after the German Baron Von Munchausen, a German cavalry officer [4] who in 18 th century wrote many travel and adventurous stories. This disorder has also been called hospital addiction, polysurgical addiction- producing so called washboard abdomen, professional patient syndrome among many others [2,4]. Munchausen syndrome is relatively a common hospital practice and cases are likely to be encountered by most of the doctors in their lifetime. The essential feature of this disorder is that the patients have ability to present physical symptoms so well that they are able to get admission in hospital. To support their history the patient may feign symptoms suggestive of a disorder that may involve any organ or system of the body. Patients are familiar with the diagnosis of the most of the disorders that usually require hospitalization and are capable of narrating an excellent history, which may deceive even an experienced clinician. Clinical presentations are variable than are generally realized and patients present them in different ways on separate occasions. These symptoms may include haematoma, infected wound, haemoptysis, abdominal pain, renal colic, fever, hypoglycaemia, nausea, vomiting, dizziness and seizures [5,6]. These patients may use blood or faeces to contaminate urine samples, use insulin to produce hypoglycemia, or infect or scratch their

operation wounds. Such patients often insist on surgery, claiming adhesions from previous operations or other complications. Patients are usually successful in gaining admission in hospital. Once they are admitted in hospital they continue to be demanding and difficult and may blame doctors or paramedical staff for uncooperative attitude and inefficiency. They often threaten litigation and are generally abusive [6,7].

Munchausen syndrome occurs in both sexes and at all ages and all intellectual groups, which varies from subnormal to superior [7]. However there is male predominance and onset is under thirty years of age in most of the cases. There is no definitive organic cause of this condition and EEG pattern or tests for brain damage are usually insignificant. It is really difficult to assess the exact cause of this behavior. It is assumed that Munchausen syndrome is a product of individual development and environmental factors which are expressed through a basically psychopathic personality, which includes criminal tendencies, colorful lying and an urge to travel widely. These findings have been validated through psychometric testing. The final driving force, which precipitates the patient into a hospital career, is still missing and is possibly quite accidental and seems to occur at any age. There may be a period of genuine ill health or acute environmental crises such as breaking of marriage etc. Once the pattern of Munchausen's behavior becomes established then it seems to form an irresistible compulsion, although individual hospital admissions may be provoked by mood swings and minor environmental setbacks, just as alcoholic turns to his bottle and the addict to his drugs at the time of crises [8].

First case is a classical presentation of Munchausen syndrome – multiple hospitalizations in different hospitals, manipulative behaviour, disturbed family life, request for discharge immediately after surgery and aggressive behaviour towards the treating doctors. Age of onset is however slightly late but the possibility of onset before the ultimate diagnosis due to incorrect history can not be excluded in this case. Follow-up of patient in second case is expected to be more revealing and interesting since he is going to dramatize his symptom in subsequent years of his life.

This condition could be handled by setting up of a central registry to collect informations from different hospitals and then disseminate to the psychiatrist, who is called to deal with such patients. These patients must be detained in their own interest in order to study further therapeutic possibilities. Legal action in these cases is not justified. Doctors should be sympathetic to these patients in casualty department and in the ward [9].

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