A Case of Munchausen Syndrome

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Summary

A gentleman in his mid-thirties presented with an interesting history of multiple medical problems including haemophilia B, intracerebral haemorrhage and renal transplantation for chronic renal failure. While in hospital, he constantly requested for analgesia. When he was refused, he stormed off angrily. A review of his medical records showed that none of the events described in his story were true. He had been to many other hospitals with varying stories in order to receive treatment. This patient displayed the classical features of chronic factitious disorder with physical signs and symptoms, also known as Munchausen syndrome.

Key Words: Munchausen syndrome, Chronic factitious disorder

Introduction

Munchausen syndrome falls under the group of factitious disorders where physical symptoms are intentionally feigned by the patient in order to assume the sick role[1]. In these cases, external incentives such as economic gains and avoiding work are absent. The prevalence of Munchausen syndrome is not well established but it appears to be uncommon. In the medical literature, no cases seem to have been reported from Malaysia and our case may well be the first one.

The history given by our patient is fascinating and it amply demonstrates all the classical features of Munchausen syndrome as described by Asher in 1951[2]. With this report, we hope to alert health care staff towards this disorder so that the patients involved will be guided towards psychiatric help rather than be subjected to unnecessary therapies and multiple diagnostic procedures.

Case Report

Mr. TR, a 32-year-old gentleman was admitted to Hospital Kuala Terengganu complaining of severe headache. In addition to a long standing history of migraine, Haemophilia B and chronic renal failure due to gout, he had recently also undergone a CT Scan in Hospital Kuala Lumpur which he said had shown an intracerebral haemorrhage. Furthermore, as treatment for his renal failure, he claimed that he had undergone 2 renal transplant procedures in India in 1981 and 1989, with the first being unsuccessful. This, he said, was why he had a scar at his left loin area.

He demonstrated good knowledge of the names of the nephrologists and urologists in Hospital Kuala Lumpur and he was able to detail his drug treatment as being allopurinol, prednisolone and cyclosporin. As for his social history, he claimed to be a highly paid long distance lorry driver on a trip to Thailand. He explained that he often had to break journey to seek treatment for his recurring headaches and he produced documents from 2 other hospitals in Malaysia where he had received medical attention before.

Before any medication could be given to him, he cautioned the doctor that he was allergic to most conventional analgesic drugs, particularly the non-steroidal anti-inflammatory group. He also displayed a hospital letter which said he was "apparently allergic to anti-cholinergic drugs". One of the analgesics that he claimed to be able to tolerate was pethidine, but in view of the Haemophilia B, he advised the doctor to administer it intravenously rather than intramuscularly.

Nonetheless, despite being give 2 doses of 100mg intravenous pethidine over the space of 6 hours, he still complained of severe headache and demanded further analgesia from the staff. His case was then reviewed by a more senior doctor who found no evidence of a transplated kidney in the iliac fossa. When challenged about this, the patient glibly answered that he had Haemophilia B and thus had required a different procedure.

The patient was offered alternative forms of analgesia instead but he became angry and threatened to call the Head of the Surgical Unit whom he mentioned by name. Nonetheless, the medical staff did not relent and the patient then took his own discharge against medical advice and stormed off out of the ward.

The story did not end there however. In the following week, we were informed that the patient had been seen again – once in Hospital Kuala Terenganu and once at a health centre 130km away – and on both occassions, he had requested intravenous pethidine for renal colic. A search for his past medical records revealed that there had been at least 3 other occasions when he, under various guises such as being an electrical engineer or a music teacher, had told similar tales to gain hospital admission.

Finally, an enquiry with the renal staff to Hospital Kuala Lumpur solved the issue. The patient had genuinely suffered from renal calculi and colic previously, but this had resolved with treatment. Nonetheless, he continued to demand medical attention at the hospital even though all the radiological and other invasive investigations during his multiple admissions did not show any recurrence. He had even been admitted under the haematological unit under the guise of having a blood dyscrasia. However, none of the history concerning the renal transplants, haemophilia and intracerebral haemorrhage was true. In fact, what the patient actually had was Munchausen Syndrome.

Essential features of this disorder are the intentional production or feigning of physical signs and symptoms which are motivated, not through any external incentives, but by the desire to assume the sick role[1]. All of these are clearly seen in our patient and this leaves no doubt as to the diagnosis.

Discussion

Munchausen syndrome is a relatively new disease, with the first description by Asher in 1951[2]. Among the features mentioned was the patient's presentation with apparent acute illness, supported by a plausible or dramatic history. These patients had attended and deceived an astounding number of hospitals and they nearly always discharged themselves against advice after quarreling violently with the doctors. Asher's description of the syndrome was based on the Raspe's writings concerning the 18th century army officer Baron Munchausen. As with our patient, the infamous Baron was widely travelled and he was renowned for the fascinating (but untrue) tales that he told of his adventures.

Under the more recent DSM-IV criteria, Munchausen syndrome would be considered as a chronic factitious disorder with physical signs and symptoms. DSM-IV listed a number of features that were found in patients with such factitious disorders[1]. Such patients often gave histories with dramatic flair and pathological lying in a manner that intrigued the listener (pseudologia fantastica). They also showed extensive knowledge of medical terminology and medical routines. Complaints of pain and requests for analgesics were also commonplace. When confronted, the patients would deny the allegations or rapidly take their own discharge, only to show up at another hospital soon after, possibly under a different name or address. These features are all well illustrated in our case.

One unique feature in our setting though, is that patients registering with hospitals are required to produce their Malaysian government issued personal identity cards. Crucially, this proved to be the undoing of our patient as he could not hide under another guise and we were able to easily trace his medical record in detail. In other patients with factitious disorders, the sign of a surgically scarred "checkerboard abdomen" may also be a vital clue.

The aetiology of Munchausen syndrome is not well established. As in our patient, some cases have genuinely had medical therapy for an organic illness before and this may have led them to become dependent on the safe, nurturing environment of a

hospital[3]. Childhood deprivation and antisocial personality traits may be associated features. Wherever possible, patients should be referred for psychiatric consultation. However, successful therapy for patients with Munchausen syndrome is extremely difficult given their penchant for wandering and taking their own discharge when confronted. As such, early recognition is crucial in order to avoid time and expenditure being wasted on potentially harmful investigations and treatments in these very willing patients.

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An Unusual Case of Oesophagopleural Fistula

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Summary

In 1985, a 12-year-old patient with pulmonary tuberculosis developed a pneumothorax. It was left untreated because he did not agree to chest tube insertion. After completion of anti-tuberculous therapy the patient failed to come for follow-up. Nine year later he presented with reactivation of tuberculosis and a pyopneumothorax. Chest tube drainage was instituted but rice was seen emerging from the tube and radiological investigations showed an oesophagopleural fistula. The patient refused any surgical procedure and was treated with conventional anti-tuberculous chemotherapy. His symptoms have resolved and the fistula appears to have healed with conservative management.

Key Words: Oesophagopleural fistula, Tuberculosis