MUNCHAUSEN SYNDROME IN A TEENAGER. A CASE REPORT
Smaranda Diaconescu¹, M. Burlea¹, Amalia Constantin², Gabriela Păduraru¹, Claudia Moscalu³, Smaranda Bunea³, V. V. Lupu¹

¹“Gr T Popa” University of Medicine and Pharmacy Iasi, Vth Pediatrics Clinic  
²Clinical psychologist, Children’s Emergency Hospital “Sf. Maria”, Vth Pediatrics Clinic  
³Resident in pediatrics, Children’s Emergency Hospital “Sf. Maria”, Vth Pediatrics Clinic

Abstract: Authors present a case of Munchausen syndrome, a factitious disease of unknown etiology in a teenager girl aged 17. The patient has been diagnosed with Helicobacter pylori associated gastritis successfully treated in our clinic, with normal endoscopic aspect and negative CLO-test and microscopy at two month check-up. She has two suicide attempts, a voluntary ethylic alcohol intoxication, followed by multiple admissions into different services from our hospital (gastroenterology, cardiology, nephrology, surgery) and in other hospitals (Infectious Diseases, Neuropsychiatry). She frequently addressed to the hospital, with various complaints usually worsening after standard therapy (peregrination). The total number of hospitalizations was 34 (166 days) in 3 years. Another characteristic of the disease, „pseudologia fantastica”, was also present, the girl told different stories about her family, about one of her friend’s death and about a rape that she was victim of. Psychological and psychiatric examination showed medium IQ, sadness, low level of self-esteem, anxiety and depression. Risk factors for the disease were identified: separation from the mother in early childhood, emotional neglect, physical and possibly sexual abuse. Psychological counseling and anti-depressive therapy were initiated, but medication has to be stopped because the girl left home and the treatment can’t be continued without an adult surveillance. The patient is lost from our evidence because she changed her residence (another behavioural pattern of the disease), but she will probably be found in the next years in the records of various adult clinical services.

Key words: munchausen syndrome, factitious disease, peregrination, emotional neglect, abuse.

INTRODUCTION
The Munchausen syndrome was initially described by Asher in 1951 and represents a pathomimesis associated to serious emotional distress, pertaining to factitious disorders group. (1) Without describing specific causes, the syndrome fits a bio-psycho-social pattern. The main characteristic of this syndrome is the simulation of acute episodes of some organic diseases. This attitude seems to be rather occasioned by the wish of such persons to be perceived as ill, than running away from responsibilities, possibility to obtain material advantages or the amelioration of their clinical and biological status.

The diagnosis requires the systematic inquiry of the symptoms described by the patient, in order to exclude any organic health problems, psychological assessment and psychiatric examination. The evolution of such cases is encumbered by frequent hospital admissions, iatrogenic risks due to invasive investigations, or aggressive
treatments recommended by physicians based on their concern and wish of not being tricked with errors of diagnosis or rare diseases. Suicidal trends can also be remarked. (2) We are presenting the case of a 17 years old adolescent girl, for whom the psycho-social traumas suffered in her early childhood (family abandonment and sexual abuse) led to the Munchausen syndrome occurrence.

CASE PRESENTATION

Patient C.A, currently aged 17, urban residence, began her series of admissions to the „Sf. Maria” Children Hospital in Iasi three years ago, in the pediatrics gastroenterology clinic, for the investigation of an abdominal pain. Her personal physiological history was not significant, and her personal pathologic one revealed attempted rape two years prior to her first arrival in our service. Her parents were divorced (mother leaving the family 12 years before) and her father was a chronic alcohol user. The history of the disease begins in January 2008 when the patient approaches our clinic, complaining of abdominal pains, mostly located in the epigastrium, associated with nausea and vomittings.

The clinical examination confirmed the painful complaints and the laboratory data were within normal limits. The upper digestive endoscopy showed esophagitis, diffuse gastritis and duodenitis. Rapid CLO-test and the microscopic examination of the gastric biopsies revealed the presence of H. Pylori. The patient lefted the hospital with an ameliorated condition, and the usual triple therapy against H. Pylori for 7 days followed by one-month anti-secretory treatment was recommended. The check-up after two months revealed the symptomatology disappearance, normal biological tests and the eradication of the bacterial infection. During the same year, she had two attempted suicides by voluntary ingestion of Distonocalm (a combination between propranolol, atropine and amobarbital) and benzodiazepines.

The psychological examination revealed that the patient has an average IQ level, sad emotional state with accents of depression and a history of physical and emotional abuse (as her parents were divorced the patient lived with an alcohol consumer father). The personality of the adolescent was forming and structuring at that time, she showed difficulties in setting and maintaining relationships and adaptability, within a context of low tolerance in frustration and frequent depressive episodes. As her nature was easy to influence and she had a high suggestibility, she described fatigue, irritability, increased emotivity, emotional unbalance which couldn’t be exclusively blamed on the confusing period of teenageing. The psychological tests also showed frequent, repeating depressive states, within the context of the serious dysfunction in her family. She was advised to change her living environment, a better management of the living conditions, promotion of a positive affective atmosphere, personal and familial psychotherapy.

The psychiatric examination: anxiety and depression episode, deliberate self-hurting by drug ingestion. At the time of her first attempted suicide, we tried to
guide the child in a children psychiatric service, but we couldn’t obtain the approval of the legal representative (her father didn’t come to the hospital and the girl was released from the hospital by a relative); on the second try, the patient was considered psychiatric emergency and transferred to the Socola Hospital of Iasi, where an anti-depressive and anxyolitic treatment was started. After several months, she came back due to voluntary intoxication with ethylc alcohol, and was reassessed from a psychological and psychiatric perspective: history of psycho-traumas, anxious tendencies, affective deficiencies, adjustment disorders and depressive moods.

The patient declared that she “no longer lives with her father”, that she „is sharing a place to live with a schoolmate” and that „she works after school”. Considering the fact that the adolescent can no longer be supervised by an adult the intervention of the social assistance services was recommended and the resuming of treatment was postponed. Further on, she came to the hospital for an acute abdomen episode and was admitted to the pediatrics surgical clinic where her appendix was removed. During the following two years (2009-2010) the child was admitted 12 times in the gastroenterology clinic; the admissions were made through the ER unit of our hospital where the patient was brought by the County Ambulance Services following her personal phone calls. Anyway, the child was never accompanied by any legal representative or adult each time she came to the hospital. Despite the significant subjective complaints, the clinical examination and the laboratory tests made did not reveal any pathological changes (the endoscopic examination showed a normal esogastroduodenal mucosa and the gastric biopsy excluded infection with *H. Pylori*).

Three admissions to the cardiology clinic added to the previous ones, also through the ER services for a polymorphous symptomatology (palpitations, effort dyspnea, lipothymia), but the normal EKG, chest X-ray and echocardiography excluded a potential cardiopathy. Other nine admissions to the surgical clinics were registered for different and significant pains, an admission to the nephrology clinic for a suspected renal colic (the echography, abdominal X ray and MRI examination showed no calculi), as well as an admission in the general pediatric service for the investigation of a cephalalgia (the neurologic examination and the CT were normal). She was also admitted to the Infectious Diseases Hospital with a suspected swine flu, unconfirmed virusologically, in her hospital recording being mentioned a possible handling of temperature control by the patient. In three years the patient had 34 hospital admissions and 166 days spent in hospital, with obvious repercussions on her school issues (she had to repeat the 10th grade). She is currently out of the clinic’s records, since she changed her residence.

**DISCUSSIONS**

The Munchausen syndrome is described in 1951 as a distinct psychiatric entity beeing named after the Prussian baron famous for his lies about supposed
military successes. The characteristics of this entity are: willful production of symptoms by dangerous manipulation of one’s entire body (for instance voluntary infection of wounds or medullar inhibition by self-administration of cytostatics) for the purpose of obtaining hospital admission, successive admissions in different clinics, cities and sometimes even countries, as well as the so-called „pseudologia fantastica” – as the patient talk about exceptional own achievements, relationships with famous people etc. (2) A particular clinical form is MSBP, in wich a “good” parent wants to induce factitious symptoms and illnesses in a child. (3)

There are no epidemiological studies on this disease, the literature being composed of case presentations, some of them being anecdotic. There are several remarks of some studied persons, most of them males, aged between 30 to 50. The anamnesis of these patients provide incomplete information that are not supported by any medical document; they claim the most diverse reasons in order to impede any contact between the medical staff and the family or friends of the ill persons. As a general rule, there is a history of abandonment or emotional and/or physical abuse during childhood. (2, 4) The claimed symptoms sometimes repeatedly refer to a certain organ, and other times to different systems.

The clinical examination sometimes reveals multiple scars, generally postoperative ones, but which may also point to a history of autolytic attempts. (5) The setting of investigations in such case is very difficult, since the patients knows detailed, sometimes surprising information on certain diseases, as well as certain methods to change the results of the laboratory data (self-administration of insulin in order to obtain a hypoglycemic status, adding egg white in the patient urine sample the result of which is a false proteinuria). (2) This is the way the patients manipulate, test and provoke the medical staff, exploiting at the same time the physicians’ fascination to diagnose a supposed rare disease, which leads to multiple drawing of different biological products, to repeat tests even if their values are normal and to to invasive diagnosis procedures.

This attitude is also explained by the natural concern of any physician of not committing any medical error by ignoring or not fully investigating certain signs and symptoms. The laboratory and imagistic investigations are in most cases normal. The psychological evaluation and psychiatric examination may show identity disorders, hypersensitivity, improper control of wishes and impulses, deformed perception of reality and unstable interpersonal relationships, sometimes feelings of guilt, doubled by the associated need to be punished or to pay for this one. (4, 6, 7) Frequently the patients refuse or don’t cooperate with the psychologist – psychiatrist team.

The differential diagnosis needs to be made by relating to converse troubles, hypochondria, somatic conditions, as well as certain diseases with fluctuant evolution and systemic involvement, such as collagenosis, multiple sclerosis and certain metabolic diseases. (2) Only the cases associated to depression or anxiety of Munchausen syndrome requires drug
therapy. In our case we identified as risk factors for the disease the abandonment in her early childhood, the emotional, physical and possible sexual abuse. The distress experienced by a child following the separation from one or both parents by divorce or abandonment, the separation from those who should be closest to them and their placement in the relatives’ care may trigger behaviour problems especially in adolescents. (8) In our patient, the relational dynamics was seriously troubled due to the fact that she had grown up in a dysfunctional family, having a vitiated childhood, being frequently forced to witness altercations, conflicts and violent acts between her parents. Hence the occurrence of chronic maladjustment problems and of somatic signs that represented a form of psychological defense. It is a known fact that in situations of long term stress the patient may unconsciously select a symptom as a metaphor for its psycho-social condition, as a conversion; it is an unconscious process of transposing anxiety or psychiatric difficulties in a somatic symptom. (7, 8) Simulation of disease was made consciously but behind these acts there are unconscious need to receive care and attention. (6) With any new admission the patient submits wrong personal data and the meeting with her father or an adult of her family is hard to obtain (the girl initially stated that her father is not in the country, then that she lived with an uncle, then with her grandmother, and finally she said that she lives with a friend).

Elements pertaining to pseudologia fantastica are present: in one of her suicidal attempts, she declared that this was caused by the death of close friend from cardio-respiratory arrest; then she told about another girl admitted to the hospital that she was her step-sister she had cut the connection with. Even her stories about sexual abuse are contradictory: initially it was about a colleague, then the neighbour of a schoolmate. After multiple attempts, we succeeded in contacting the father but he came drunk to the hospital and a constructive discussion was hard to achieve; however he seemed familiar with the real motivation of his daughter’s behavior but did not wish to get involved in her upbringing and education as well as he claimed us to address to the Child Protection Agency.

In evolution, new complaints, more and more significant ones, occur periodically. The patient simulates imaginary manifestations, false or exaggerate ones, often self-driven (voluntary ingestion of drugs, alcohol consumption). She shows symptoms which are hard to control, suggesting a cardiopathy, a chronic digestive disease, a central nervous system illness or possible post-appendectomy complications. The symptoms aggravate or change in the same time the therapy for various diagnosis suspicions is started. The performed investigations, including those of high accuracy such as the upper digestive endoscopy, CT and MRI cannot confirm an organic disease. From this point of view we wish to underline the high costs of such a case from the perspective of the accommodation services offered by the hospital, the exhaustive investigations and long-term treatments.
CONCLUSIONS

The Munchausen syndrome is comprised in the group of simulative disorders; it cumulates a multitude of subjective manifestations and sufferings sometimes self inflicted, acute or chronic, proteiform and repeated, causing the transition of such patients through various medical facilities with the aim of gaining attention from the specialized personnel and a possible hospitalization. The disorder is primarily a psychiatric problem and the result of psycho-social stress (being known that this may accelerate or alter the evolution of a distress) and of consecutive personality disorders which lead to perturbations on the level of ideas and biologic vulnerability.

Diagnosis is difficult to perform due to the contrast between the abundant background history, impressive and confusing, the complex but not specific symptoms summary and the striking poverty of objective manifestations. The physician, bound by a hippocratic approach, must provide assistance and sometimes extensive and expensive explorative procedures of a suffering which is mainly imaginary. These unhealthy individuals are exposed to certain iatrogenic risks but as well to a potential lack of credibility in case of real conditions or diseases. Although it is rare, the possibility of a Munchausen syndrome must be considered when suggestive manifestations are present; the evaluation of these cases by a psychologist and a psychiatrist is needed.

REFERENCES: