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Munchausen syndrome. The case from practice

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Munchausen syndrome (factitious disorder) is one of the forms of the personality and behavior disorder. It can lead to the severe physical and psychical complications. The paper presents major data and analysis on the different clinical forms of the Munchausen syndrome on the basis of literature analysis and the author's own observations and investigations. The necessity of the timely diagnosis and creation of the juridical base for analysis of clinical situations was grounded in the case of Munchausen syndrome.

Key words: Munchausen syndrome, factitious disorder, person's disorder and behavior.

Munchausen syndrome (factitious disorder) relates to a borderline mental disorder. It is one of the forms of personality and behavior disorder when a person seeks medical assistance for some somatic symptoms either factitious or produced intentionally claiming that they are the signs of a real pathological condition. Falcity is meant in it already. However, these patients are not aimed at obtaining any material benefit. The main life goal of such patients is hospitalization and the process of treatment and staying in hospital is more important for them than the result. It is noticed that these conditions can develop after real somatic illness, loss of a loved one, solitude. Such individuals are characterized by disorders of self-assessment, self-control, including poor sexual adaptation. They have strong need on dependence, but being disappointed they go to the world of fantasies and daydreams [4, 5]. These patients demand medical staff attention but they try to avoid contacts with psychiatrists, as subconsciously they understand the core of their problem. That is why they prefer to visit the hospitals late in the evening, at night or in holidays when they expect young and inexperienced doctors to be on call in the emergency room. They also try not to visit primary care physician and policlinics and never appear in the same hospital twice. The literature describes a case when one such 'baron Munchausen' managed to visit 60 hospitals within a year. According to different authors, the Munchausen syndrome rates vary from 0.8 to 9% [6, 7, 16]. However, reliable epidemiological studies have not been conducted yet due to the difficulty to diagnose such conditions. It is interesting to note that the intelligence quotient of these patients is normal or higher middle level and they don't present formal thinking deviations. At that they can get interested in special medical literature and know the clinical picture of factitious disorder inside out. The disease has its peak in the age of 15–30 years, but it can be developed in childhood too. To date not any randomized study of this condition therapy efficacy has been conducted yet. There isn't any one established therapy method, as these patients represent heterogeneous group. This problem can be worsened in individuals with Munchausen syndrome with marked aggressive behavior, psychoactive substance abuse and illness simulation in order to receive them, persistent intention towards mutilation. Such patients can be seriously dangerous for themselves and require hospitalization to the mental health unit to prevent injuring themselves. Many of them can have drug abuse and criminal records, easily moving from a prison to a hospital and back [11,12, 16]. In current medical practice different synonyms of Munchausen syndrome are used — «professional patient» syndrome, «hospital addiction», «poly-surgical addiction», «hospital flea», «fraud». According to ICD-10 classification the syndrome is referred to the header «Intentional production or feigning of symptoms of disabilities, either physical or psychological, factitious disorders». Psychiatrists treat this syndrome as a part of hysterical disorders. English researcher Richard Asher was the first to describe this condition in 1951 while examining false patient obsessed with the incessant addiction to treatment. It was named after a really existing «the most honest storyteller» baron Munchausen [1]. German baron Karl Friedrich Hieronymus von Munchausen (1720–1797) was famous as a teller of extraordinary stories. He even published a book «Handbook for merry fellows» with his stories. His name became common after German writer Rudolf Erich Raspe (1737–1794) published in England the stories about baron Munchausen. Baron Munchausen went to Russia being 17 years old and lived there for 15 years. He was a witness of palace revolutions, favorites' ups and downs. He served in the Russian Army. Famous House of ice described in the like-named novel written by Lazhechnikov was built when he lived in Russia. When he came back to Germany he had a lot to tell about Russia. However, at that time listeners wanted another stories — about the animals running in the streets, about the snow covering the villages up to the roofs and so on. It is interesting to cite him — 'Russia is the biggest country in the world that is why Russian people like everything grandiose. Everywhere you will be shown the highest bell tower, the tallest man or the fattest woman. It is the nature of the Russian people: they know no measure in anything. That is why they have their symbols of state shown in the Kremlin — the great Tsar Cannon and the giant Tsar Bell. However, this cannon does not shoot and the bell does not ring. If everything shoots and rings at them, then the Russian people rein the world undoubtedly.' Later baron got a nickname «lugen-baron» — «baron-liar» and his pavilion where he told his amazing stories was called «lie pavilion» [17]. However, baron fame is phenomenal, and perhaps no one of the famous heroes described in the literature of XVIII century (Robinson Crusoe, Lemuel Gulliver and others) is as popular, interpreted and dramatized as Karl Friedrich Hieronymus von Munchausen. However, behavior and life style of the «Munchausens» can be life threatening. R. Ahser pointed 3 main clinical types of the syndrome:

1. Acute abdominal type (tomomania).
2. Haemorrhagic type (hysterical bleeding).
3. Neurological type.

The **first** type of the syndrome (the most common and the less difficult to recognize) is presented by external signs of acute abdomen and the signs of previous laparotomies as multiple scars. The «barons» complain of severe abdominal pain and insist on immediate surgery often simulating perforated gastric ulcer. Supplement diagnostic tests (for example, blood count with leukogram) show absence of acute abdominal pathology with inflammatory process. If they are refused to

be urgently operated, the patients, which were demonstratively writhing with pain, can leave the hospital immediately in order to be admitted to another hospital with acute abdomen the same night. Some patients can swallow foreign objects to get the desired surgical intervention — spoons, forks, nails, medical instruments and secure the surgery this way. The most important thing is that after abdomen opening in these patients there is no pathology or signs of inflammation, obstruction, ulcer, adhesions found which can be the reason of such pain. One should note that hysterical pains are hardly distinguished with physical ones and the doctors seeing these conditions and having difficulties in explaining its reasons are inclined to make a surgery.

With **haemorrhagic type** (hysterical bleeding) the patients have periodic natural bleedings but mostly enforced bleedings from different parts of the body. Sometimes they use the animal blood plus skillfully made cuts which all together make the impression of natural injuries. The patients are admitted at the hospitals complaining of «catastrophic bleeding», «significant hemorrhage» alleging to be life threatening. In this connection it is possible to compare the mechanism of these conditions development with so called «vicarious» hemorrhages of fanatical Catholics, which during the menstruation have blood appeared on their palms and feet where the nails of the Christ's crucifixion were driven. We can quote some interesting words of baron Munchausen from the like-named novel of R. E. Raspe — 'Everybody in my place would be afraid. But I knew my way around and decided to use this moment.' [19].

At the **neurological type** of the syndrome the sham patients have acute neurological symptoms (paralyses, faints, seizures, complains of headache, unusual shakiness). Sometimes such «Munchausens» insist on the brain surgery. It is necessary to separately analyze the demonstrative fits in terms of the differential diagnostics with the epileptic fits, as they are met often. Paroxysms are usually developed following the unplesant experience, quarrel and sometimes as a result of too much care of close ones about the well-being of a patient. At first a patient experiences unplesant feelings in the heart, palpitation, feeling of 'out of air running', a lump in the throat; they appear as a reaction on the mental disturbances. The patient falls down, convulsions develop, often of tonic character but they can be clonic or tonoclonic too. The convulsions are often the complicated movements. During the fit the patient turns red or pale in face, but he/she is not bluish or red-bluish like in epilepsy. The eyes are closed, when somebody tries to open them the patient closes his/her eyes tighter. Sometimes the patients rebd clothes, beat their head against a floor. At that they always should have an audience, without audience a fit does not develop. In case of an epileptic fit there could be no people around and the patient can bite the tongue, involuntary urination and defecation are possible. Unlike the epileptic fit, a person does not fall down suddenly (the patients fall little by little, they can fall on the bed, couch or armchair and they never have self-inflicted serious injures), pupillary response to light is saved as well as the ciliary and lid reflexes. Crying or crying and lauphing at the same time often procede the seuizures. The patients moan or scream out some words. Fits never occur in a sleeping person. Usually when a person falls he/she has no bruises or biting the toung (but he/she can bite the lip or cheek). He/she is concious, at least partially. The patient remember about the fit. They have no involuntary urination, they can't get asleep after the fit. Much oftener the fits are less marked and the patient sits or lays down, starts crying or laughing, making some chaotic movements with the limbs (mainly arms). The gestures can be theatrical with attempt to tear their hair, scratch the body, throw the things available around. Motor disturbances usually occur like muscle paralyses (pareses) (of the limbs mainly), contractures, impossibility of difficult movements or different hyperkinesias. Arm hysterical monoplegia (paresis), hemiplegia, lower paraplegia are often recorded. However, other muscle paralyses are possible: of neck, tongue, face. One should remember, that they are not paralyses in a literal sense to occur but imposibility of voluntary movements, that is why the patients can not have isolated paralyses of particular agonists. Contractures affect the limb joints but they can develop in the spine, the muscles of the neck (hysterical torticollis) and of the face (eye muscles spasm). The patients can fix their body in mannered poses, which are not observed in organic lesions. Motor disturbances can occur as a psychogenic inability to stand and walk. At that in prone position the muscle strength and range of motions are kept. The reflexes are alive and the muscular tonus is not changed. The patients with conversion movement disorders have no characteristic pose of really paralized people. One should mention the variety of hyperkinesias: tremor of the whole body or of some its parts, head hyperkinesia in the form of the rotatory movements, tics of the facial muscles and body muscles. As a rule the above-mentioned paralyses, contractures, hyperkinesias disappear during sleep [1,7,11].

One should separately distinguish the main psychological characteristics in these patients. Such craving for medical care and tests is characteristic for hysterical personalities with excessive emotionality. Their feelings are superficial, unstable; their emotional reactions are demonstrative and dramatic and do not correspond to the reason caused them. To resist any conflict such people prefer to sink into the illness and hide from the problem. In return they receive attention, sympathy, some of their demands are fulfilled and other people undertake their responsibilities. It suits the sham patients. Excessive emotions can result in damage of sensation mechanism and consequently disorders in the form of megalgias in the skin, muscles and bones appear. Sufferings in such patients are real enough. Such hysterical individuals are characterized by high suggestibility and autosuggestibility that is why they can constantly play some role and imitate the personality who amazed them. Russian physiologist, academician I. P. Pavlov thought that a temporary mental disorder under the influence of psychologic traumatic experience, giving some benefit in such situation to a hysterical person could be fixed by the mechanism of conditional reflex development. It forms the basis of the hysterical fixation of the morbid symptom. The complexity of the problem also lies in the fact that when such patient appears in the hospital, he/she can imitate the symptoms of the other patient diseases which are treated in the same ward. Formation of the disorders imitating physical suffering often goes as a reproduction (by the imitation or identification mechanism) of the disease symptoms which could be observed in a specific real patient within long period of time [11,12].

Later a few more types of Munchausen syndrome were distinguished: cardial type (imitation of angina, myocardial infarction); lung type (imitation of tuberculosis and other chest diseases); skin (self-inflicted injuries of skin up to indolent ulcers development). Mixed (poly-symptomatic) type was also distinguished. It can include different symptoms of the above-mentioned disorders. Unusual and rare types of Munchausen syndrome were described when, for example a woman in late pregnancy provoked premature labor pains pinking her fetal bladder with a long hairpin, or a patient imitating acute porphyria stole urine for analysis from a patient

with real porphyria [8, 10]. In 1977 English pediatrician R. Meadow distinguished a separate variant of Munchausen syndrome — by proxy (according to the words of witness). It is a severe form of the child abuse when parents fictitiously fabricate and induce a disease in their child and the child is a victim of this falsification [9]. The following conditions are stimulated and provoked the most often: bleedings (using the drugs affecting blood coagulability, injury of the mucous membrane of the anus and oral cavity, using the blood of another person or animal, paints), convulsions (fraud, using the drugs which can cause convulsions, asphyxia), sleepiness, sluggishness (using the drugs inhibiting central nervous system, asphyxia), diarrhea (fraud, using laxatives). One can often find foreign objects in stomach, lungs and large intestine in children. According to some authors the victims of Munchausen syndrome were recorded among the children with the sudden death syndrome — up to 35% of all the cases of sudden death syndrome, observed by the authors within 23 years [14,15].

It is a mother who most often fabricates the disease history of a child. It is noted that mothers provoking diseases in children suffer from deficiency in psychological support out of family, are unhappy in marriage and part of them have mental disorders. Their majority (more than 90%) went through physical and mental abuse in childhood. If factitious, fabricated nature of a child disease is revealed, they deny the infliction of harm even if the evidence is available and refuse any therapy. The diseases caused factitiously are hardly treatable, that is why children have higher risk of more unnecessary medical procedures which can affect them including their mental state. It should be noted that influence of the physical abuse on the child mental development can have more serious consequences than the physical trauma itself. According to some authors it is possible to assume the presence of Munchausen syndrome if the following signs are observed:

— performed examination has not shown any pathology, however, the patient keeps complaining;

— examination results do not coincide with the course of a disease;

— the experienced specialists tell — «I have never met such case before»;

— initial diagnosis — a very rare disease;

— a mother is not satisfied with the conclusion about pathology absence;

— a mother possesses a lot of medical data;

— no symptoms when a mother is absent;

— a very careful mother who refuses to leave her child at least for a short time on various excuses;

— routine treatment methods have no results [2, 3, 13, 18].

It is necessary to distinguish some features of a conversation with the parents which are necessary in such situations when the parents are sure that their children have a serious, severe pathology (when it is absent), as it could irreversibly affect the child health (both physical and mental). It is better to talk with the parents without child participation. It is necessary to avoid the direct criticism of their behavior, as it can cause hostility and the parents will refuse to cooperate. As a result, a family and a child will not get the necessary assistance. If there are two parents and it is possible, it is better to talk with each one separately.

It should be also noted that currently in Ukraine there is no appropriate legal juridical base on treating such situations and the doctors themselves can be exposed to stress impact while treating such patients. In case of Munchausen syndrome a doctor encounters lie and self-destructive behavior of a patient who tries to involve the doctor into it. The problem takes both ethical character, as in any model of doctor-patient interaction (liberational, paternalistic, interpretating, technological) the main bioethical principle is to be applied — the respect towards patient's autonomy, open communication and honesty which the «barons Munchausen» lack. That is why all above-mentioned emphasize the seriousness of this matter while managing such patients and reasonability to develop juridical base on treating such situations.

Here is another one clinical case. The patient M. B., 15 years old was taken to the pediatric psychoneurologic department with the diagnosis 'acute poliomyeloneuropathy, deep flail legs'. He complained of the pains in the right buttock spreading to the leg, pains in the area of sacroiliac joints, walking problems, inner agitation. He got sick 12 days ago when after physical exercise and being at fishing in cold weather the above-mentioned complains and fever appeared. He was treated in the Central District Hospital within 3 days in the neighborhood from where he was referred to the pediatric surgery department of the City Hospital where he received treatment within a week (antimicrobial and infusion therapy, non-narcotic analgetics, antihistamines, vitamins of B group). On the day of admitting to the Institute Clinic cervical, thoracic and lumbosacral spine MRI was done (to specify the diagnosis and to possibly further adjust the therapy). No pathological changes were revealed. During the objective examination, specifically at studying the neurological status, no disorders of cerebral nerve functions were recorded. No sensory and coordination abnormalities were detected, abdominal reflexes were alive, no pathological reflexes were observed, tendon reflexes were within normal. Positive Lasegue stretch symptom was observed at the right. Radiography of hip joints was done — joint spaces were not changed, no destructive changes in the bones forming the joints were detected. Taking into consideration the data of the medical history, objective examination, absence of pathology in MRI and radiography a conclusion was made that the patient had the residual effects of the acute neuropathy of the right sciatic nerve with the conversion layerings and appropriate therapy was prescribed. A few important factors should be mentioned which were found during medical history taking and in the process of treatment. The boy suffered psychological trauma, as his father left the family and moved to the other woman, his mother got married for the second time and gave girth to a new child who was devoted much attention. When he got sick he lived in care of his grandmother and felt himself alone. His mother earned money in another country. The features of his character were hypochondria, emotional lability, difficulties in communication and normal interaction with people, particularly with children of his age, reservedness, inclination to loneliness, missing lessons at schools. He had also broken up with his girl whom he courted. In this connection the child gradually developed the behaviour model which allowed to reconstruct desired by him situation filled with attention, love from the family and people around and it was mixed with the disease state appeared after supercooling. The boy wished to see his mother by his side who learning about what happened came to him and started taking care of him. Consultation with the pediatric surgeon and orthopaedist, abdominal ultrasound did not reveal any pathology. After the next examination at which the patient stood and walked on toes and heels, he was detected no pathological reflexes, disorders of the cerebral nerve functions, sensitivity and coordination. He heard about positive dynamics in his state and correspondingly that his mother presence by his side was not necessary. The next day the patient started complaining of the increased pain in the right buttock and sacroiliac joints, pains in legs

and back, he did not want to get up and let his mother go. When he was asked to get up, he did it with difficulty, leaning on the arms and making 'mannered' movements with his body. When asked he was able to stand on toes and heels. The muscle strength in feet was saved. No pathological reflexes were observed. The tendon reflexes were equal and alive. Sensitivity was not damaged. Positive Las?gue stretch symptom was observed at the right. The patient was consulted by the psychiatrist. Behavior suppression, weak depressive state, emotional lability, absence of mental activity productive pathology were observed, demonstrative behavior in form of hyperpain syndrome was not excluded. To sedate and eliminate inner agitation sibazon was prescribed intramuscularly. Increase of the temperature up to 38°C, increase of ESR and leukocytosis in complete blood count were observed in the patient. When the patient was examined by the otorhinolaryngologist, bilateral otitus was diagnosed. After that the therapy was adjusted correspondingly with the further normalization of the temperature and laboratory parameters. According to the electromyography data, the moderate reduction of the parameters of the right sciatic nerve function was recorded in the patient, mainly owing to S1 root and a conclusion was made «S1 radiculoneuropathy at the right, subacute stage». It confirmed the initial diagnosis. The patient state normalized, the gait and range of motions stabilized during the therapy and he was discharged from the hospital in satisfactory condition. In the described case the psychologic traumatic background of the family was a significant factor in conversion layering appearance. The patient tried to sink into the illness, to obtain attention care and sympathy towards his state. Therefore, till the psychologic traumatic background of the family does not change, he could try to sink into the illness in order to get sympathy like love and care.

While managing the patients with Munchausen syndrome the very important moments are detection of the factors stimulating factitious disorder development, the analysis of the family and social situation, thorough examination and recording, coming into contact with them, their validation and elimination of the destructive and self-destructive tendencies. It is connected with the fact that in such situations a relationship between a doctor and a patient can be damaged, a doctor can feel disability because he/she is unable to stop the destructive behavior of a patient who doe not want to accept that he is involved into self-destruction. As a result a doctor can feel a desire to unmask the patient and accuse him/her of a lie. That is why it is necessary to manage your emotions and surely to involve psychologist and psychiatrist into the treatment process and to develop the juridical base for reviewing such situations.

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Синдром Мюнхгаузена. Случай из практики

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Синдром Мюнхгаузена (имитирующее расстройство) представляет собой одну из форм расстройств личности и её поведения, что может привести к тяжёлым физическим и психическим осложнениям. На основании литературных данных и собственных наблюдений и исследований, в статье приведены основные сведения и анализ разнообразных клинических форм синдрома Мюнхгаузена. Обоснована необходимость своевременной диагностики и создания юридической базы по рассмотрению клинических ситуаций в случае синдрома Мюнхгаухена.

Ключевые слова: синдром Мюнхгаузена, имитирующее расстройство, расстройство личности и поведения.

Синдром Мюнхгаузена. Випадок з практики

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Синдром Мюнхгаузена (імітуючий розлад) являє собою одну з форм розладів особистості та її поведінки, що може призвести до тяжких фізичних та психічних ускладнень. На підставі літературних даних та власних спостережень і досліджень, в статті наведені основні відомості та аналіз різноманітних клінічних форм синдрому Мюнхгаузена. Обґрунтована необхідність своєчасної діагностики та створення юридичної бази щодо розглядання клінічних ситуацій у випадку синдрому Мюнхгаузена.

Ключові слова: синдром Мюнхгаузена, імітуючий розлад, розлад особистості та поведінки.

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НОВОСТИ

Капуста, щавель и шпинат способны предотвратить слепоту

Глаукома, высокое внутриглазное давление, является одной из главных причин полной потери зрения в современном мире. А ученые обнаружили, что опасность развития глаукомы заметно уменьшается при регулярном включении в рацион вполне доступных овощей.

Исторически сложилось так, что большинство людей из всех разновидностей овощей отдают предпочтение корнеплодам и бобовым (картофелю, свекле, гороху, фасоли, моркови, огурцам и тому подобное).

Отношение же к так называемым листовым овощам (щавель, шпинат, петрушка укроп, салат, латук и так далее) несколько иное — подобная «зелень», за исключением разве что капусты и ее родственников: брокколи и цветной капусты, рассматривается как необязательное дополнение к основному рациону.

Подобная «дискриминация» листовых овощей связана с их низкой калорийностью и они традиционно не рассматриваются как источник энергии.

Между тем, американские исследователи обнаружили, что природные соединения азота, которым очень богаты листовые овощи, способны снижать риск развития глаукомы, опасного заболевания органов зрения, которое наряду с макулярной дегенерацией сетчатки глаза является основной причиной слепоты современных людей.

Например, в США в настоящее время имеется 3 миллиона жителей, страдающих глаукомой, а 120 000 американцев полностью потеряли зрения из-за осложнений этого заболевания.

Ученые из медицинской школы при Гарвардском университете (Harvard Medical School) на протяжении четверти века с 1986 по 2011 год наблюдали группу жителей США численностью почти 105 000 человек (64 000 женщин и 41 000 мужчин).

Участники исследования регулярно информировали ученых о результатах проверки их зрения, а также об индивидуальных особенностях их питания.

Анализ полученных ответов показал, что у той подгруппы участников исследования, которые потребляли листовых овощей больше других испытуемых, риск развития глаукомы был ниже на 30% по сравнению с участниками, которые такие овощи употребляли в пищу нерегулярно.

Подобным эффектом в наибольшей степени обладала кудрявая капуста (кале).

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