Familiar Munchausen syndrome: an unusual presentation

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Síndrome de Munchausen familiar: una presentación inusual

Summary

Munchausen syndrome is a subtype included in factitious disorders in which somatic signs and symptoms predominate. The patient self-inflicts damage with the only objective of assuming a «sick role." This is an underdiagnosed disorder characterized by numerous hospital admissions and history of visits to different medical specialists. Early diagnosis would avoid high health care costs caused by unnecessary explorations, and social, work and familial deterioration of the patient. We report a case with two affected brothers, rare in the literature reviewed, and we analyze suspicion criteria in the daily clinical practice.

Key words: *Factitious disorder. Munchausen syndrome. Familial disorder. Simulation disorder.*

Resumen

El síndrome de Munchausen es un subtipo dentro de los trastornos facticios en el que predominan los signos y síntomas somáticos. El paciente se autoinflinge un daño físico, con el único objetivo de asumir el rol de enfermo. Es una patología infradiagnosticada, caracterizada por numerosos ingresos hospitalarios y una historia de peregrinaje por diferentes especialistas. Un diagnóstico precoz evitaría el elevado gasto sanitario ocasionado por las exploraciones innecesarias y el deterioro sociolaboral y familiar del paciente. Se describe un caso que afecta a dos hermanos, infrecuente en la literatura revisada, y se exponen los criterios de sospecha en la práctica clínica diaria.

Palabras clave: *Trastorno facticio. Síndrome de Munchausen. Trastorno familiar. Simulación.*

INTRODUCTION

Factitious disorders represent one of the most underdiagnosed diseases in the daily psychiatric practice[1,2]. This is probably due to the absence of diagnostic suspicion and difficulty in the differential diagnosis, especially in initial stages. These disorders are characterized by self-provocation by the patient of physical or psychic symptoms in absence of external incentives on the contrary to simulation. In the Munchausen syndrome, also called hospital addiction syndrome or polysurgical addiction syndrome, the harm is exclusively physical and includes a history of visits to different specialists and hospital with numerous hospital admissions.

Since it is still a medical enigma, it would be important to suspect this disorder when a symptom lacks a logical biological or psychosomatic base. In this sense, we describe two cases of first degree family members (siblings) who were diagnosed of the Munchausen syndrome after a long history of medical care. After reviewing the bibliography in this regards, this familial presentation is an unusual situation.

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CLINICAL CASES

Clinical case 1

A 33 year old male who is admitted for a surgical intervention in 1996 due to picture of duodenal ulcer that is resistant to medical treatment. As background of interest, there is repeated tonsillitis and study due to suspicion of childhood glomerulonephritis that led to several hospitalization at an early age. An abnormal familial dynamics stands out; the patient was the third of nine siblings, alcoholic father and brother diagnosed of «unspecified neurosis». In the seriated controls in the outpatient clinics in the following years, the patient complained of abdominal and non-specific precordial pains, requiring the specialist to perform many ultrasonographic type imaging tests, CT scan, digestive barium X-ray series, without reaching a specific diagnosis. Furthermore, in the following years, he continued to come to the Emergency Services, with a frequency of 8-9 times a year, due to pictures suspicious of upper digestive bleeding, that were not confirmed endoscopically in the suc-

cessive admissions. At the same time, in all the cases in which he was not hospitalized, he requested evaluation in different hospitals and during the vacation periods in centers of other cities, with the consequent repetition of the complementary tests. Parallelly, on a personal level, there was significant work absenteeism, with alteration on the familial and social level. In the hospitalization ward, the patient hardly collaborated, with frequent complaints of pain, demanding analgesics and insisting on the performance of inadequate complementary tests, in order to prolong the hospital stay, requesting the voluntary discharge when his purposes were not achieved. On three occasions, he self-inflected superficial wounds with a weapon with a blade in both forearms. When faced with the suspiciousness of the diagnosis, and when the patient was offered an explanation on the possible factitious origin of his symptoms, he became more distant and denied the self-provocation of the symptoms at all times.

Clinical case 2

A 39 year old male, bother of the previous patient, comes to the Emergency service in 1997 due to epigastric abdominal pain picture secondary to supposed mild abdominal trauma. The background was similar to that reported by his brother previously, since he had been coming to the Emergency Service on repeated occasions for several years, demanding admission, reporting nonspecific abdominal pain whose organic origin was never demonstrated. He was only hospitalized on one occasion, due to a hypoglycemia picture, that was later related with the intake of glucose lowering drugs. In regards to later evolution, the x-ray tests requested in the Emergency service showed sharp foreign bodies compatible with nails, lodged in the gastric chamber that required extraction by urgent laparotomy. After a difficult anamnesis, the patient confessed having swallowed them hours before. In spite of an out-patient follow-up, the patient entered into a dynamics of numerous visits to the Emergency Service in successive years. He took part in the self-intake of foreign bodies of all sizes, as nails, screws, tweezers, clips and even a closet knob (figs. 1 and 2) that required extraction by endoscopic approach or urgent laparotomy on numerous occasions. This patient also did not collaborate for the psychiatric approach.

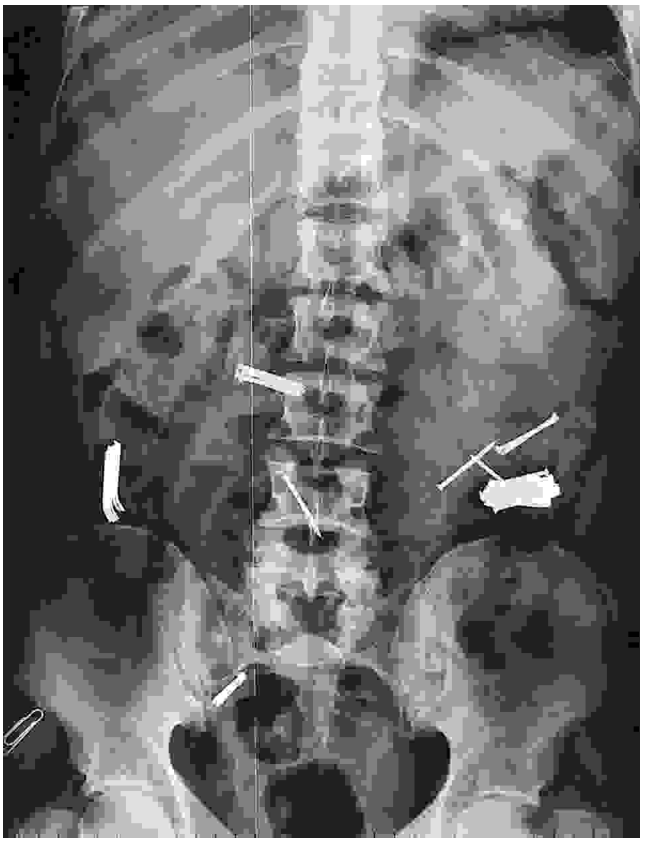

Figure 1. Simple X-ray of abdomen showing many foreign bodies (tweezers, nails, clips) in digestive tract corresponding to clinical case 2.

DISCUSSION

It is not part of the health care staff training to doubt the truthfulness of the clinical history given by the patient. However, the clinician can find disorders in which the patient pretends to have symptoms or intentionally harms him/her self in order to obtain medical care. The prevalence of this disorder is unknown, although most studies coincide in verifying that it is underdiagnosed[1,2]. The familial presentation of this type of disease is very rare, and we have not found any case like those we have described in the international bibliography reviewed.

Several etiopathogenic hypotheses have arisen, although none of them have been conclusive. In 1951, Asher described three types of clinical presentation: acute abdominal, neurological, and a third one characterized by hemoptysis or hematemesis[3]. Since then, many cases have been reported and occur in most of the medical specialities, among them hypoglycemias[4-6], cardiac disease[7], lupus erythematosus[8], gonarthritis[9], hemoptysis[10], gynecological disease[11], dermatológic[12], infectious such has HIV[13] or neoplasms[14]. Cases of self-provoked pneumothorax[15], or need for surgery in the area of general surgery[16], esthetic surgery[17], neurosurgery[18], or traumatology[19] have even been described.

Even though this is a difficult and risky diagnosis, there are some data that can help us to suspect this entity. On a psychobiographic level, there can be a background of repeated hospitalizations in childhood, as occurs in one of the patients presented; in other cases, they are persons close to the health care setting. The history of visits to seek hospitalization, including several specialists and health care centers, is typical. High comorbidity on the psychiatric level with a borderline disorder of the personality, characterized by impulsiveness and low to-

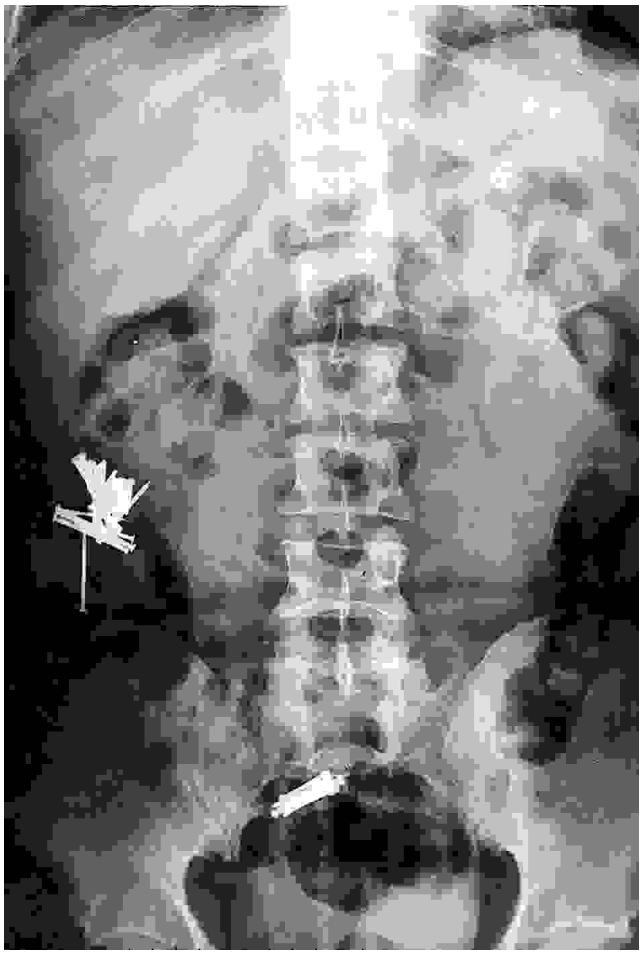

Figure 2. Many packaged nails impacted in the colic frame and sigma corresponding to the patient of the second clinical case.

lerance to frustration, materialized on occasions by impulsive suicide attempts, as occurs in one of the cases described, is also generally frequent. This disorder can often be suspected in the context of substance abuse or even in eating disorders[20].

During the anamnesis, the use of technicisms by the patient, together with a defiant attitude in the face of the clearness in the diagnosis is typical. In this sense, the growing inclusion of medical data in Internet and chats with medical subjects could lead to the appearance of new cases of Munchausen syndrome[21] in the network. In the admissions, they are generally litigant and manipulating, requested voluntary discharge if they do not a-chieve the examination requested.

The differential diagnosis, especially with simulation, is important and sometimes complicated. As is observed in the patients described, after the performance of a detailed review of the clinical history, the only benefit was the desire to be hospitalized in order to undergo surgical procedures or invasive diagnoses. They generally present exaggerated periods of hospitalization, many drug treatments and repeated visits to the Emergency service, which, together with the medical iatrogeny generated, shape this disorder as a chronic and severe disease. In this way, a detailed clinical history, faced with the presence of suspicion data, is essential.

Given that it is still a disorder that has not been resolved in the therapeutic field, the best treatment arises from correct diagnosis. A multidisciplinary approach between the different medical services involved is advocated in order to avoid the consequences described and thus to avoid the consequent social, work and familial deterioration of the patient.

Once the diagnosis is confirmed, the approach, in practice, is complicated. The professionals involved must avoid a critical attitude and accusing type questioning, considering the existence of an underlying emotional problem. In every case, psychiatric treatment and a psychological approach should be offered, seeking therapeutic alliances and trying to substitute self-destructive behavior by other constructive ones[22].

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