Early onset Münchausen's syndrome

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Síndrome de Münchausen de presentación precoz

Summary

This study presents a clinical case description of a factitious disorder in a woman whose diagnosis was made during her childhood. The onset of the disorder took place at 12 years of age and the fundamental clinical characteristics are: limited frequency with which the diagnosis is made in this period of life as well as the multiple symptoms manifested by the patient, both abdominal as well as neurological and hemorrhaging ones. A careful analysis of the personality traits and biographic history of the patient was also perfomed. The characteristics of the factitious disorder in childhood, as well as the relationship of this syndrome with the personality disorders, are discussed.

Palabras clave: *Factitious disorder. Pediatric. Personality disorder.*

Resumen

En el siguiente trabajo se presenta la descripción de un caso clínico de un trastorno facticio en una mujer cuyo diagnóstico se realiza en la edad infantil. El inicio del trastorno tiene lugar a los 12 años de edad y las características clínicas fundamentales son la escasa frecuencia con que se realiza el diagnóstico en esta época de la vida, así como los múltiples síntomas que manifiesta la paciente, tanto abdominales como neurológicos y hemorrágicos. También realizamos un análisis detenido de los rasgos de personalidad e historia biográfica de la paciente. Se realiza una discusión respecto a las características del trastorno facticio en la infancia, así como la relación de este síndrome con los trastornos de personalidad.

Palabras clave: *Trastorno facticio. Infantil. Trastorno de personalidad.*

INTRODUCTION

Factitious disorders are characterized by the intentional or feigned production of physical or psychological signs or symptoms. On the contrary to the simulators, persons with factitious disorder «apparently do not obtain any benefit, except for the discomfort of the unnecessary examinations or surgical interventions.» It appears that these patients have the single objective of acquiring the patient role.

In 1951 Asher began to use the term Münchausen's syndrome to describe this type of patients. He adopted this term from the Rudolf Erich Raspe's book titled *Baron Münchausen's Narrative of His Marvelous Travels and Campaigns in Russia (1784),* in which the exaggerated stories of the warlike and sports adventures of Baron Karl Friederich von Münchausen were described.

Asher described three main presentation patterns of this syndrome, according to the type of symptoms reported by the patient:

- *Acute abdominal type.* The patient presents a history of multiple abdominal surgery, with surgical interventions.
- *Hemorrhagic type.* Characterized by simulated hemoptysis and hematemesis.
- *Neurological type*. In which feigned neurological symptoms such as headache, seizures or loss of consciousness predominate[1].

The main classifications used at present, ICD-10[2] and DSM-IV, differ in the location of the factitious disorders. The former includes them within personality and behavior disorders of the adult. On the contrary, the DSM-IV[3] includes this disorder in the somatomorphic disorders, but within a separate epigraph (table 1).

CLINICAL CASE

This is a woman who presents a long history of hospitalizations, motivated by different changing symptoms and signs over time since 12 years of age. She was studied on repeated occasions by different specialities, with multiple complementary examinations whose results were always normal. Continuous visits to the emergency services of several hospitals of the city, as well as multiple admissions, led to the application of invasive examinations and even surgical interventions.

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TABLE 1. Differences between ICD-10 and DSM-IV

DSM-IV	*ICD-10*
It classifies the factitious disorder as a different category, that is, it creates a separare epigraph for this disorder	It includes the factitious disorder within the group of personality and behaviour disorder of the adult
It differentiates several subtypes, according to the symptoms with which it is manifested: physical, psychological or both	It does not recognize different subgroups according to the clinical manifestations
It also recognizes Münchausen's syndrome by proxy within the factitious disorder	It excludes Münchausen's syndrome by proxy of the factitious disorders and considers them as physical abuse in childhood

The symptoms manifested by the patient at the onset of the disorder were abdominal pain and pain in the renal fossa, so that she was assessed by surgery, digestive, gynecology and urology specialists, and also had multiple visits to the emergency services. All the complementary examinations performed were normal, and she was diagnosed of renal colic, ovarian pain, non-specific abdominal pain, etc., on different occasions.

At 14 years of age, she was hospitalized in neurosurgery as she presented headache, dizziness and vomiting, after a cranioencephalic trauma. During the admission, it was observed that the patient provoked vomiting in order to prolong her hospitalization. When she was discovered, she was referred to the mental health center for treatment, however, the collaboration of the patient was very little, coming to the appointments with irregularity and with poor treatment compliance.

In the following year, at 15 years of age, she was hospitalized a total of five times, in the urology, general surgery and digestive services. In addition, she was studied by gynecology as an out-patient. The manifestations reported by the patient during this year increased progressively, so that fever, amenorrhea, diarrhea, hematuria, dysuria, extreme urinary frequency, and continuous urinary urgency were added to the above mentioned symptoms. during this period, she underwent many blood, hormone and urine analyses, as well as radiological examinations (plain X-ray, CT scan and MRI), ultrasonographies and two urgent exploratory laparotomies. She received different diagnoses, such as nephritic colic, salpingitis and chronic inflammatory intestinal disease. In addition, she was given different treatments such as wide spectrum antibiotic therapy, immunosuppressants and hormones.

In two of the hospitalizations, it was observed that she had no fever when her temperature was taken by the health care staff. On one occasion, a second thermometer with a temperature of 38º hidden in her pajama was even discovered.

Two new admissions took place the next year, when the patient was fifteen years old. Abdominal pain, fever and hematuria repeated as symptoms, so she was assessed by the digestive and urology service. In the last admission in the Digestive Service and after a review of the clinical history, the diagnosis of Münchausen's syndrome was suggested for the first time. In spite of this, the visits to the emergency service and admissions continued. When the patient was confronted with the diagnosis, she requested voluntary discharge and change of hospital.

She requested to be seen in our hospital, where the frequent admissions and invasive interventions as well as complementary examinations were repeated. A new laparotomy was performed in which no abnormalities were found in the abdominal cavity and multiple examinations were performed, even an electromyography to dis-card porphyria. Hospitalization was prolonged and was complicated by the appearance of new symptoms which had neurological characteristics, in form of hemiparesis and hemianestesia, that were not congruent with the neurological examination. Finally, the manipulation of the thermometers and the urine samples was verified, discovering that she added blood, obtained from the peripheral line, simulating hematuria (the samples were not hematuric as they were obtained by catheter). She also reported amenorrhea, and it was finally discovered that she had hidden the sanitary napkins during her menstruation.

During the admissions to our hospital, we began to have contact with her through the psychiatric referral service. Several interviews were held, giving special attention to the reconstruction of the clinical history and to the information provided by the mother, finally confirming the diagnosis, after verifying the manipulation of the patient towards the exploratory samples.

The hospitalizations continued afterwards, altering between the reference hospital and other hospitals of the city. New surgical interventions were even considered on several occasions, however, the mother, who reported the background of her daughter, refused to have them done.

The out-patient psychiatric follow-up was irregular (due to the absence of awareness of the disease), so that adequate psychotherapy could not be carried out.

Biographic history and premorbid personality

The patient is the daughter of three siblings and belongs to an unstructured family. Her parents separated when she was 7 years old. The next year, her mother had to be hospitalized and three years later underwent surgery.

After, the family went to live in Valencia from a town in Jaen, and lived in the home of an aunt on her mother's side and with her family. When the patient was 15 years old, her aunt died and shortly afterwards, her grandmother.

The character traits of the patient were obtained from the interviews maintained with the patient and her family, basically her mother. Since her childhood, frequent lies and stories were discovered; she accused her father and stepfather of physical abuse, facts that were never verified and of which the family itself had its doubts. She had low tolerance to frustration and a manipulative atti-

tude since she was very young, causing self-lesions when she was made angry. She was a poor student with frequent and unjustified absences, unknown by her family. She did not finish her primary studies.

Her work history is unstable, performing sporadic work, basically as a caregiver, in which she does not maintain continuity. She managed to be hired by stating that she was suffering a serious illness and was going to die. She neglected her work tasks, even leaving the patients she cared for alone.

She is also unstable in her interpersonal relationships. In spite of her young age, she had maintained multiple relationships, even several at the same time.

DISCUSSION

The interest of this case presented herein is found in the onset at 12 years of age, during childhood.

Following the Asher classification, commented in the introduction, three types of factitious disorders are differentiated according to the presentation form of the symptoms: abdominal, hemorrhagic and neurologic. The case in question has the characteristic of presenting the three groups of symptoms at the same time. The patient initially began with abdominal type, and received multiple examinations in this sense, including three exploratory lapartomies. Progressively, other groups of symptoms were added, such as headache accompanied by dizziness, vomiting and hemiparesis (neurological type). She also presented the hemorrhagic type on reporting hematuria. This form of presentation, due to its complexity, is not usual in patients with factitious disorder, since the manifestations are generally focused on a single syndromic group, that is maintained constant during the evolution.

There are many traits in the personality of the patients with factitious disorder that lead us to think about a personality disorder. The close relationship between these two disorders is clear in the last edition of the International Classification of Disease, that place factitious disorders within the spectrum of personality disorders. The differential diagnosis can be proposed with the antisocial disorder and above all with the personality borderline disorder. In the case of the antisocial disorder, many similar behavior patterns can be found: onset at early ages, lack of acquisition of social values, difficulty in family setting relationships, adaptation difficulty to scholastic demands, delinquency, etc., on the other hand, they are different in that these patients would not allow the administration of multiple examinations and invasive interventions. However, it is the borderline disorder that poses diagnostic difficulty most frequently, due to its unorganized life type, difficulty to maintain personal relationships, frequent lies, that even enter within the fantastic pseudology, toxic abuse, etc., the extremely frequent comorbidity being that which complicates the diagnosis and treatment[8].

Although Münchausen's syndrome in childhood is not considered in the classifications of diseases (ICD-10 and DSM-IV) or in the existing classifications of factitious disorders, some special characteristics are described during this period. When the literature existing at present in regards to the factitious disorders in the pediatric population is reviewed, it is observed that few cases have been published[4].

In the year 2000, Libow published a review of the cases described during the last 30 years, and as a result, he obtained only 42 descriptions of factitious disorders that would have been exclusively produced by the child or adolescent population.

The clinical characteristics that are observed in this study in regards to Münchausen in childhood are:

— Predominance in girls (71%).
— Mean age of 13.9 years.
— Lesion mechanism: fever, purpura, intoxications, etc.[5]

The hypothesis that is proposed in the face of the few cases described is that this disorder is probably underdiagnosed in childhood[6], the true extension of the problem being unknown since most of the cases detected in the adult age have frequently begun in young or adolescent age. This has great importance if we consider that the prognosis of this disease may depend how early this diagnosis is made and initiation of treatment, above all, because the disease worsens and treatment is more difficult in untreated children. Another reason that can be adduced in relationship to the limited prevalence of this disorder in childhood is that many of the cases are diagnosed of somatizations initially.

Some authors consider that the children who suffer this type of disorder have learned this attitude after having been victims of the so-called Münchausen by proxy; others, on the contrary, do not agree with this statement and consider that it is more frequent that the parents who perpetrate Münchausen by proxy would have suffered this factitious disorder in their own childhood[7].

Thus, a door remains open for the study and differentiation of Münchausen's syndrome by proxy.

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