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Received: 24.01.2019

Accepted: 27.03.2019

Published: 31.05.2019

Munchausen syndrome by proxy – a case report

Przeniesiony zespół Münchhausena. Opis przypadku

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Abstract

Child abuse may take different forms. Munchausen syndrome by proxy is a factitious disorder in which disease symptoms are induced in a dependent person so that the perpetrator could play the role of a caregiver. Parent (mother in most cases) is usually the perpetrator, and a child is usually the victim. The desire to draw the attention of medical personnel, which can be a psychological reward, is the main motivation for a person affected by Munchausen syndrome by proxy. The scale of the problem remains unknown due to diagnostic difficulties. We present a case of a 10-year-old girl who was initially hospitalised for more than 2 months due to unexplained bleeding from the lower gastrointestinal tract, and was then admitted to another paediatric unit due to consciousness disorders. Accurate diagnosis and prevention of further child maltreatment was possible due to collecting thorough medical history, diagnostic vigilance and cooperation between medical centres where the girl was hospitalised.

Keywords: Munchausen syndrome by proxy, diagnostic difficulties, child abuse syndrome, haematuria, factitious disorders

Streszczenie

Krzywdzenie dziecka może przybierać różne formy. Jedną z nich jest przeniesiony zespół Münchhausena, który należy do grupy zaburzeń pozorowanych i charakteryzuje się indukowaniem objawów chorobowych u zależnej od siebie osoby w celu wcielenia się w rolę opiekuna chorego. W większości przypadków sprawcą jest rodzic (najczęściej matka), natomiast ofiarą dziecko. Główną motywacją do działania osoby cierpiącej na przeniesiony zespół Münchhausena stanowi chęć zogniskowania na sobie uwagi personelu medycznego, co może być psychologiczną nagrodą. Z uwagi na trudności diagnostyczne skala problemu pozostaje nieznana. W niniejszej pracy przedstawiono opis przypadku 10-letniej dziewczynki, która początkowo przez ponad 2 miesiące była hospitalizowana z powodu niewyjaśnionego krwawienia z dolnego odcinka przewodu pokarmowego, następnie zaś trafiła do innego oddziału pediatrycznego z objawami zaburzeń świadomości. Ustalenie właściwego rozpoznania i uchronienie dziecka przed dalszym maltretowaniem było możliwe dzięki zebraniu dokładnego wywiadu, czujności diagnostycznej oraz współpracy między dwoma ośrodkami, w których hospitalizowano dziewczynkę.

Słowa kluczowe: przeniesiony zespół Münchhausena, trudności diagnostyczne, zespół dziecka maltretowanego, krwinkomocz, zaburzenia pozorowane

INTRODUCTION

Munchausen syndrome is a mental disorder in which the patient deliberately induces or simulates disease symptoms and undergoes unnecessary treatment, motivated by the desire to draw attention of healthcare professionals. The syndrome was first described in medical literature by Richard Asher in 1951⁽¹⁾. It owes its name to Baron Munchausen, an 18th-century officer who was known for exaggerating stories, in which he allegedly took an active part.

Munchausen syndrome by proxy (MSbP), in which somatic symptoms are induced in a child by a parent or a caregiver, is a different diagnostic unit. The difference between these two syndromes is that the symptoms are self-induced in Munchausen syndrome, while in MSbP, the symptoms in the child are induced by a caregiver⁽²⁾. It involves both inducing an illness (by administering toxic substances), and simulating clinical symptoms. MSbP is a dangerous form of child maltreatment, which was first described in 1977 by a British paediatric nephrologist, Roy Meadow. He presented two cases of children with fictional diseases – a patient with haematuria due to the presence of maternal blood in patient's urine and a child who died from salt poisoning^(3,4).

Several terms of the disorder are used in English literature, such as Meadow's syndrome, Munchausen syndrome by proxy, factitious disorder imposed on another (FDIA). "By proxy" literally means as a substitute. In this case, the substitute is a person, usually a child, who is the victim of a person affected by MSbP⁽⁵⁾.

A few to several MSbP cases are reported annually in Poland (on average 3/100,000 children). It should be noted, however, that literature reports usually describe severe cases. Therefore, the actual scale of this form of maltreatment remains unknown⁽⁶⁾. Approximately 1,000 of the 2.5 million cases of child abuse reported in the USA are related to MSbP⁽⁷⁾. Yates and Bass showed in their meta-analysis of 796 cases that child's death was reported in 7.4% of cases⁽⁸⁾. Long-term disability is reported in 7.3% of children⁽⁹⁾.

According to the definition presented by Rosenberg, MSbP is diagnosed when child's illness is fictitious or induced by the caregiver; the contact with medical professionals is aimed at conducting multiple medical procedures; the caregiver negates the causes of the child's illness; and the symptoms resolve when the child is separated from the caregiver⁽¹⁰⁾.

- Extensive and inconsistent description of child's disease
- Clinical picture uncorrelated with medical history reported by the parent
- Acceptance of invasive diagnostic and surgical procedures without any doubts
- Seeking attention and understanding from medical personnel
- Requests for further interventions and opinions of other specialists
- Medical knowledge
- History of mental disorders
- Family problems

Tab. 1. Warning signs in the perpetrator⁽¹¹⁾

Warning signs that should draw doctor's attention are shown in Tabs. 1 and 2⁽¹¹⁾.

It is believed that the main goal of a person affected by MSbP is to be the centre of attention. This is associated with the need to feel the power or release stress related to a difficult life situation. The attention paid by medical professionals may be a psychological reward for the caregiver⁽⁵⁾. Yates and Bass reported that 97.6% of perpetrators are women, and 95.6% are the victim's mothers. About 45% of perpetrators are involved in professions related to healthcare. Also, MSbP is more common in parents who were victims of abuse or experienced family drama in childhood (30%). Furthermore, the caregivers are more often diagnosed with mental disorders in the form of factitious disorders, including the Munchausen syndrome (30%), personality disorders (18.6%) and depression (14.2%)⁽⁸⁾. MSbP may be also triggered by strong stress, e.g. marriage problems⁽⁵⁾.

It should be also noted that the range of possible symptoms induced by the perpetrator is very wide. These include fever and skin conditions as well as endocrine, gastrointestinal, haematological, neurological, metabolic and rheumatic diseases^(12–15). The perpetrator is able to successfully simulate clinical symptoms despite child's hospitalisation in 54% of cases⁽⁸⁾.

MSbP usually affects adults, mostly the mothers. Therefore, the treatment is focused on the mother rather than the child, who is only a victim of maternal abuse. The management involves discontinuation of unnecessary medical care and reversal of the consequences of the caregiver's actions. The caregivers are offered long-term psychiatric therapy and psychological supervision. Cognitive-behavioural psychotherapy is also recommended. The treatment should last for many years. Mothers with previously confirmed MSbP should be assessed for potentially harmful behaviours towards the child and be taught to accept an unwanted child^(5,7,16).

CASE REPORT

A 10-year-old girl was admitted to the Department of Paediatrics, Paediatric Nephrology and Allergology of the Military Institute of Medicine due to fainting and vertigo. The patient was referred from a school nurse's office, where vital parameters, such as blood pressure, pulse, and saturation, were checked and were normal. On admission it was found that an outpatient urinalysis performed a few days earlier revealed haematuria.

- Unusual clinical picture
- Normal laboratory tests
- Clinical symptoms not responding to treatment
- Clinical symptoms occurring in the presence of the caregiver, and resolving during the absence of the caregiver
- New complications or symptoms in the case of normal test results
- History of multiple hospital stays and surgeries
- Many comorbidities (including mental disorders)
- Father absent in the child's life

Tab. 2. Warning signs in the victim⁽¹¹⁾

The child, who was not diagnosed with any chronic conditions, underwent appendectomy 6 months earlier. Since then, several positive faecal occult blood tests were reported. As a result, the girl was diagnosed in another paediatric unit for more than 2 months, where a number of diagnostic tests were run: fiberosigmoidoscopy, gastro- and colonoscopy as well as double scintigraphy using technetium-labelled erythrocytes, in the search of ectopic gastric mucosa. Also, positive symptoms were observed during hospital stay. Head computed tomography and abdominal/central nervous system magnetic resonance imaging showed no abnormalities. The last fiberoscopy revealed a single, very shallow perirectal fissure. No signs of ischaemia were found in laboratory tests during a nearly 2-month hospital stay despite constant presence of blood in faeces. According to the mother, another hospital stay was planned in the department of paediatric surgery in order to perform an exploratory laparotomy.

On admission to the Department, the girl was in moderate general condition, apathetic and drowsy. Apart from confusion, physical examination revealed no other significant abnormalities. Laboratory tests showed low inflammatory markers, normal peripheral blood cell count, normal liver and kidney function markers. A capillary-blood gas test showed no water-electrolyte or acid-base imbalance. Faecal occult blood test was negative. Due to haematuria observed prior to hospital stay, ASO titre coagulogramme was assessed and the results were normal. In the urinalysis, red blood cells loosely covered each high power field. A decision was made to collect patient's urine samples in the presence of medical personnel. Urinalysis showed leucocyturia, with 3 to 5 red blood cells per high power field. Due to the unclear result, urine was collected for another urinalysis – also in the presence of medical personnel. No abnormalities were found. Due to the abnormal somnolence of the child, toxicological tests of both urine samples were performed and presence of quetiapine was revealed in the sample collected from the patient in the presence of a nurse. After obtaining this result, medical personnel's vigilance was increased and all visits were registered. The girl could not explain the presence of the drug in her body. None of her caregivers admitted to knowing the drug or administering it to the child. A consultant psychiatrist raised a suspicion of inducing health- and life-threatening symptoms in the child.

It was noted by medical personnel that the mother hardly ever left the unit, demanded further tests, and suggested the direction to which the diagnosis should be extended. It was found that the girl's grandmother (on the mother's side) was a long-term hospital worker (secretary), and that the girl's mother was unemployed after being dismissed from her recent jobs, including a medical secretary. The girl's parents divorced during her infancy. The patient had a good relationship with her father and his family. It was also found that when the patient's mother was 9 years old, her 19-year-old sister died tragically.

Due to the unclear clinical picture, the girl's attending doctor in the paediatric unit she recently stayed in was contacted. It was found that the medical team in this unit did not set any date for another hospitalisation for exploratory laparotomy. Furthermore, psychiatric consultation was performed due to the positive symptoms presented by the girl, which for the first time raised a suspicion of MSbP-related disorder. Additionally, faecal blood was verified genetically due to the repeated positive faecal occult blood test and normal results of additional tests. The results obtained about one month after discharge indicated human blood other than the patient's own, which could belong to a woman closely related to the girl. After obtaining the abovementioned genetic testing results, and based on the findings from psychiatric consultation, the attending physician and the head of the department reported the case to the Family Court and the Ombudsman for Children. The case remained in progress. The whole clinical picture, multiple hospital stays, suggesting the direction of diagnosis by the child's mother, abnormal test results only for samples collected without the presence of medical personnel, and the presence of a psychotropic drug in the child's body allowed for the diagnosis of MSbP.

Due to the confirmed actions threatening the health and life of the child, the police were notified and a decision of the District Court was obtained to entrust the care of the girl to her father during the proceedings. Care in a specialist centre for abused children was also recommended.

DISCUSSION

The described case is a classic example of MSbP. A seemingly overprotective mother, professionally involved in healthcare, with a history of childhood trauma, whose aim was to subject the child to multiple and, as it turned out, unnecessary tests and prolonged hospital stays. Although it was not possible to prove that it was the mother who administered quetiapine, i.e. a drug used in the treatment of psychotic disorders, in the child, she remained the main suspect.

The patient had spent more than 2 months in hospital before the diagnosis could be established, and was again hospitalised in a paediatric unit shortly after. Therefore, it should be emphasised that medical professionals play an important role in both the initiation of the syndrome and making it permanent. Particular vigilance of doctors is needed when medical history does not correlate with physical examination and laboratory findings. In the case of doubts, all laboratory tests should be repeated in the presence of medical personnel. Furthermore, toxicology tests should be performed in the case of suspected poisoning or administration of drugs by the caregiver in order to induce symptoms. In the case of unclear test results, significant patient's social history and, consequently, suspected MSbP, it is of great importance to contact the facilities where the child was previously hospitalised. This allowed to rapidly direct the diagnosis in the described case.

Doctors of all specialties may encounter MSBP. Greater awareness of the disorder among professionals involved in primary and inpatient health care will allow for a more rapid diagnosis. It should be noted that the actual scale of the problem remains unknown due to the low diagnosability of the disorder. Particular vigilance is needed in cases of extensive medical history, disproportionate laboratory findings and significant patient's social history (mental disease, childhood trauma). This will allow to avoid multiple unnecessary tests as well as provide the caregivers with therapy and, consequently, prevent further maltreatment of children. This form of maltreatment, apart from the obvious negative impact on the child, may also have distant consequences.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations, which might negatively affect the contents of this publication and/or claim authorship rights to this publication.

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