Münchhausen's syndrome

Synonyms: Munchausen's syndrome, factitious disorder, hospital addiction syndrome

The term Münchhausen's syndrome was first used by Richard Asher in a paper in 1951, taking the name of the legendary Baron von Münchhausen who was renowned for his wide travels and dramatic and untruthful stories [1] .

Münchhausen's syndrome can be characterised by three features:

- Simulated illness: either physical or psychiatric.
- Pathological lying (pseudologia fantastica).
- Wandering from place to place (peregrination): the patient typically presents to numerous different hospitals, using different names.

In Münchhausen's syndrome [2] :

- Symptoms can be simulated - eg, contamination of specimens to look like haematuria, haemoptysis, haematemesis.
- A pre-existing illness can be aggravated.
- Disease may even be self-induced - eg, eating contaminated food to cause food poisoning.

People with Münchhausen's syndrome may go through unnecessary tests, operations, or uncomfortable investigations and procedures. They can cause themselves considerable injury. Costs incurred to health services for these repeated admissions and procedures can be huge.

There is a related condition formerly known as Münchhausen's syndrome by proxy in which a parent or carer produces factitious illness in a child or adult in their care. See the separate Fabricated or Induced Illness by Carers (FII) article.

Diagnostic criteria

Münchhausen's syndrome is not included as a discrete mental disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5). The official diagnosis in this classification is 'factitious disorder'[3] .

However, many psychiatrists identify a subset of patients with factitious disorder and subclassify them as having Münchhausen's syndrome. One way of looking at Münchhausen's syndrome is as an extreme variant of factitious disorder.

Factitious disorders are placed among the somatic symptom and related disorders because somatic symptoms are dominant in both disorders and are often encountered in medical settings.

Epidemiology

- Data from the central Norwegian patient registry showed a prevalence of only 0.0026%; however, careful review revealed that diagnoses were frequently incorrect and far too rarely made. A one-year prevalence of around 1-5%) is likely to be closer to reality in clinical populations. Numbers vary depending on the specialty. The (suspected) diagnosis was made in 7.5% of pre-selected patients in a psychosomatic consultation liaison service. Systematic reviews of published case studies reported a high proportion of case reports in psychiatry (19%), accident and emergency departments (12%), neurology/neurosurgery (10%), infectious diseases and dermatology (9% each), and endocrinology (13%), as well as cardiology and dermatology (10% each).
- Patients are more commonly male[4] .
- Female patients do occasionally occur and are sometimes seen during pregnancy[5] .
- Most patients are white.
- Most cases reported in the literature are aged 30-50 years.

Aetiology and predisposing factors

- There is little hard evidence of aetiology because it is a rare condition and it is difficult to engage people with Münchhausen's syndrome in analytic therapy.
- There is suggestion that Münchhausen's syndrome and fabricated or induced illness by carers (formerly, Münchhausen's syndrome by proxy) may have much in common and they have been reported in the same individual.
- Personality disorder, depression or substance abuse may feature.
- Some theories suggest that the patient or carer may [6] :
    - Have suffered abuse or neglect as a child. The hospital is seen as a safe environment or a way to escape from everyday life.
    - Be trying to understand or cope with earlier serious illness by reliving the experience.
    - Be identifying with someone close who had a serious illness.
    - Have a very low self-image. They hope to strengthen their own identity or get sympathy for themselves or the person that they care for. The patient is also given a role in a social network by being admitted to hospital.
    - Have an inability to trust authority figures, such as doctors. They may feel the need to test them, to try to catch them out.
    - Are subjecting themselves to painful medical procedures as a form of self-punishment.

Presentation

The patient can present in a multitude of different ways.

Common presentations

These include:

- Feigning surgical illness and hoping for a laparotomy (historically known as laparotimophilia migrans).

- Bleeding alarmingly (historically known as haemorrhagica histrionica).
- Presenting with curious fits (historically known as neurologica diabolica).
- Presenting with false heart attacks (historically known as cardiopathia fantastica) [7] .
- Taking drugs to induce side-effects - eg, beta-blockers to produce bradycardia, desmopressin to induce hyponatraemia, or insulin to induce hypoglycaemia.
- Wounds may not heal properly due to contamination or interference.
- Gastrointestinal disorders such as vomiting and diarrhoea.
- Respiratory problems often with breathlessness and hyperventilation.
- Self-mutilation causing extensive scarring or loss of body parts, such as fingers.
- Malnutrition and anaemia.
- Skin discolouration produced by coloured dye (rash, Raynaud's syndrome) [8] .

Other features

These include:

- A long history of unexplained illness, often with many changes of doctor, practice and hospital, which should alert the doctor.
- They may be rather vague about the details of their illness or they may show an unexpectedly profound knowledge of the disease as if having read a medical textbook.
- There may be inconsistencies in the history.
- They are happy to accept invasive and unpleasant investigations and even surgery.
- They may be hostile, antagonistic or very dramatic.
- They may exaggerate or lie about other aspects of their lives.
- On examination there may be multiple operative scarring.

- There may be a failure to demonstrate physical signs that would be expected. For example, abdominal examination may fail to show guarding and neurological examination may fail to reveal the expected signs.

Münchhausen by internet is now a common phenomenon and one which can cause particular problems for healthcare professionals who provide online services [9] .

Investigations and diagnosis

- If the diagnosis is suspected then investigation should be kept to a minimum. However, basic procedures for responding to the patient's symptoms and signs generally need to be followed.
- Patients may interfere with samples - for example, putting blood in urine. They may also interfere with charts.
- They may ingest or inject themselves with toxic substances to produce abnormality [10] .
- Be alert to inconsistencies in the history and symptoms and signs that do not seem to fit.
- Also remember that even people with Münchhausen's syndrome can suffer from genuine organic disease.

Differential diagnosis

- **Malingering disorders**: illness is feigned to achieve an obvious gain, such as compensation or avoidance of a particular event - for example, a court appearance.
- Somatic symptom disorder: people have symptoms that cannot be medically explained but their symptoms are not deliberately produced.
- **Hypochondriasis**: the patient presents with anxiety as the main symptom and either no physical signs or medically insignificant physical signs [4] . When test results are negative, this gives the patient temporary relief.

Management

- When the diagnosis is suspected it is important to strike a balance between exclusion of serious disease and feeding the pathological needs.
- When the diagnosis seems sure, the patient should be confronted in a sympathetic way. However, they may also become hostile and aggressive if confronted.
- Psychiatric treatment may be helpful but often patients discharge themselves from hospital once their presenting condition has received attention or they change GPs if confronted in primary care [4] .
- Offers of psychiatric treatment are often rejected, but if childhood trauma has been unearthed, cognitive behavioural therapy directed towards this aspect may be acceptable [11] .
- Patients with comorbid depression may be helped by non-addictive medication such as a selective serotonin reuptake inhibitor (SSRI) antidepressant but no medication has been found to make a significant difference to the behaviour of Münchhausen's syndrome patients.
- The danger is that the patient may be denied a true need when they have organic illness.
- When a patient with Münchhausen's syndrome is identified, hospitals may keep a record of this in a 'Münchhausen's file'. However, keeping such files up to date may not always occur.
- Local hospitals may even share information about that person. The establishment of a universal electronic care record system would considerably assist in the identification of Münchhausen's syndrome patients.

Prognosis

- This is very difficult to predict due to the difficulty in tracking patients with Münchhausen's syndrome and therefore the lack of follow-up studies.
- There are also no scientifically tested treatments.

Features which increase the risk of morbidity or mortality include:

- Cases where the patient manipulates their own body - eg, self-poisoning, self-infection, aggravation of wounds, etc.
- Exposure to the risk of iatrogenic damage - eg, patients receiving unnecessary chemotherapy, surgical complications, allergic reactions.
- Harm as a result of withholding medical information - eg, drug allergies, anticoagulant use.
- 'The boy who cried wolf' - patients with a known history of Münchhausen's syndrome may not be taken seriously when they develop organic disease [12] .

Further reading

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