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Reminder of important clinical lesson

Munchausen syndrome mimicking psychiatric disease with concomitant genuine physical illness

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Summary

Munchausen syndrome is a disorder in which patients intentionally produce symptoms mimicking physical or psychiatric illnesses with the aim to assume the sick role and to gain medical attention. Once a patient receives a Munchausen syndrome diagnosis every complaint made thence tends to be regarded with scepticism by clinical staff. However, it is possible that a bona fide illness, which might be disregarded, may coexist in these patients. We report a case of MS mimicking psychiatric disease with concomitant genuine acute physical illness. Despite the initial doubts about the veracity of the latter, due to its prompt recognition, treatment was successful.

BACKGROUND

Patients diagnosed with Munchausen syndrome (MS) usually frustrate and generate doubt in care takers.[1] We report a case of a Munchausen syndrome where psychotic features and mutism were simulated alongside with a genuine medical illness. This case report may contribute to the awareness among physicians that in patients with Munchausen syndrome a genuine illness may coexist and a thorough patient evaluation should be performed whenever this is suspected.

CASE PRESENTATION

A 45-year-old Caucasian man was brought by local police to the emergency department (ED) after being found wandering in the middle of the road near the hospital. During the previous 2 weeks he had been admitted repeatedly to the ED for the same reason and each time discharged after a normal examination. Medical and neurological studies were unremarkable as were routine blood tests and CT scan, which led to a request for psychiatric examination. He collaborated poorly with accurate answers concerning time and space orientation and stating he 'didn't remember' when asked for his identification. He proceeded to claim to be suffering from auditory hallucinations and delusions of control relating both as in a classic textbook case. He then started showing gradually progressive mutism. The hypothesis of Munchausen syndrome was raised leading to admission to the psychiatry ward for diagnostic clarification.

As an inpatient he continued speechless, despite following simple verbal orders and requiring no assistance for eating or bathing. After being given writing material the patient was able to tell he suffered several head injuries in Spain and he did not remember his identity or deeds for the past 5 years. Still not speaking, at the 16th day the patient suddenly showed respiratory distress while pointing to his chest. These new symptoms divided clinical staff whether they deserved credit for veracity. However, as the clinical condition seemed to rapidly deteriorate he was ultimately transferred to the internal medicine ward where severe acute pericarditis was diagnosed. Echocardiography revealed moderate effusion with no signs of tamponade and treatment consisted of bed rest and aspirin. Although still not speaking in the convalescence period of this intercurrence, he appeared more communicative in his writing, identifying himself under what was later concluded to be a false name and claiming he had been in many different countries having lost his memory 13 years ago. On the 39th day the patient unexpectedly started communicating verbally with full fluency stating 'a big fright' had restored his speech. He reportedly claimed he had been previously admitted in hospitals in Spain and Canada for a 'nervous breakdown'.

The real identity of the patient was only determined through fingerprint analysis by the national authorities. He refused to be followed in the outpatient clinic after which he was subsequently discharged in care of the social assistance.

OUTCOME AND FOLLOW-UP

Although the medical intercurrence was treated successfully, refusal of further intervention and follow-up for the psychiatric condition points to poor patient outcome.

DISCUSSION

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision (DSM-IV-TR) factitious disorders are characterised by intentional production of either physical, psychological or mixed symptoms that simulate various clinical syndromes with no apparent advantage for the individual concerned other than allowing him or her to assume the sick role in order to receive care and support.[2] The definition applied by the International Statistical Classification of Diseases and Related Health Problems-10 is similar but adds absence of confirmed physical or other psychiatric pathology as an exclusion criterion.[3] Despite the inexistence of this last criterion in DSM-IV-TR,

diagnosis of factitious disorders should not be considered as definite and ongoing revision and further investigation should be conducted along its course. Munchausen syndrome is a specific subset of factitious disorders, usually with more extreme presentations, worse prognosis and a more refractory course than other forms of factitious disorders. Despite the fact that the secretive nature of Munchausen syndrome and of factitious disorders in general thwarts traditional epidemiological research, it is estimated that as much as 6–8% of all psychiatric admissions[4 5] and 1.3% of general hospital admissions[6] could be cases of factitious disorders.

Management of factitious disorders presents many challenges. Reports of success in treating factitious disorders are limited, but the varying case reports stress the need for a strong therapist–patient alliance.[7] It is highlighted that the first step for management is a tolerant attitude[8] and directing the efforts towards stopping self-discharge and the consequent peregrination throughout health services.[9] Although the usual effects on staff exerted by these patients are initially those of concern and empathy they gradually change into scepticism as the deceptive nature of the disease becomes apparent.[10] As a result, once a patient receives this diagnosis every new symptom presented tends to be regarded as feigned. This fact closely relates to the stereotype that considers a diagnosis of mental illness to be an everlasting entity. As a consequence, there is a tendency to interpret any abnormal behaviour or complaint in a psychiatric patient as a manifestation of the mental illness.

We described a case of Munchausen syndrome where psychiatric symptoms were the object of fabrication with an accompanying genuine acute pericarditis. The latter is a common disorder in several clinical settings. Although the exact incidence and prevalence are unknown, acute pericarditis is recorded in about 0.1% of patients admitted to hospital.[11] Potential serious complications include cardiac tamponade, chronic pericarditis or constrictive pericarditis. Although a report of factitious disorders mimicking multiple personality disorder combined with real malignant hypertension could be found in the literature,[12] this is, to the authors' knowledge, the first report of simulated psychosis and mutism with concomitant genuine physical illness.

The patient in this case had a firm diagnosis of Munchausen syndrome, which could have made clinicians dismiss the new symptoms as feigned. Prompt evaluation in this case was cardinal for recognition and management of the intercurrence.

Learning points

- A previous history of simulation does not exclude coexistence of genuine illness.
- Changes in clinical presentation in a patient diagnosed with factitious disorders/Munchausen syndrome should raise the possibility of concomitant genuine illness.
- FD is probably an under diagnosed condition, both in the psychiatric as well as in the general clinical setting.

Competing interests None.

Patient consent Obtained.

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