CASE REPORT

MÜNCHAUSEN SYNDROME BY PROXY: THE OVERLOOKED DIAGNOSIS

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Münchausen Syndrome by Proxy (MSBP) is a psychiatric disorder characterised by the adoption of bizarre behavioural patterns by care-givers in which diseases or disorders are fabricated in individuals, usually children, for purposes which span feelings of superiority derived from deceit of persons deemed superior to the care-giver, or attention seeking. The patient under discussion was a 6 year old male brought to the hospital by his mother with complaints of repetitive and unceasing passing of stones per urethra. Upon inspection of stone specimens brought in by the parents and physical examination, the stones in question were observed to be common stones, with no reason to suggest a urolithiatic origin, leading to the suspicion of MSBP. Further questioning of both the mother and father revealed more information regarding the cause of her child's illness and strongly suggested that the stones were being physically inserted into the child's urethra by the mother - often in the father's absence - after administration of sedative-hypnotic drugs.

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INTRODUCTION

MSBP, also referred to as Meadow's Syndrome, was first described by R. Meadow[1] in 1977. MSBP is a psychiatric disorder characterised by the adoption of bizarre behavioural patterns by care-givers in which diseases or disorders, or their symptoms are fabricated in individuals, usually children below the age of 6 years of age.[2] It is currently viewed as an extended form of child abuse and often requires psychiatric evaluation and treatment of both the care-giver and victim.[3]

As the child grows, they often view themselves as physically impaired, even in the absence of evidence which would suggest this to be the case.[4]

Upon review, descriptions of MBSP cases in Pakistani literature are rare which leads to MBSP often being overlooked as a potential diagnosis. In addition, awareness of child abuse is uncommon in Pakistan[5], and such disorders are often difficult to diagnose depending on the competence of the care-giver to emulate or induce the disorder, despite extensive investigations performed on the victim to reach a diagnosis. Due to this, attention must be raised towards the consideration of MSBP in cases where a diagnosis cannot be readily reached despite exhaustive investigative procedures combined with the presence of diagnostic clues commonly seen in the care-giver of the child in question.[6]

CASE REPORT

The patient, a 6 year old male, had been brought to the hospital by his parents with complaints of the persistent passing of stones per urethra, accompanied by pain and occasional bleeding.

According to the mother, the patient had been frequently passing stones per urethra for the past two years, and visiting over ten physicians had not yielded an accurate diagnosis. Prior to this, her attending physician referred the patient to a neurologist, who subsequently advised the patient undergo urological examination.

Physical examination of the patient was mostly unremarkable, apart from minor injuries around the urethral meatus. The child appeared healthy and cognitively alert.

The patient described feelings of uneasiness shortly before passing a stone, and would seemingly awake from a state of unconsciousness after which he would proceed to strain and pass stones. Subsequently, one or more stones would be seen exiting per urethra. This chronological succession would occur during each individual instance in which a stone passed a fact which was a source of much confusion for physicians visited in the past.

A jar containing a large number of stones said to be passed by the patient, and a video taken during one such occurrence was presented as evidence. Upon examination, the stones showed a large variation in shape, size and colour (Figure 1) and did not appear to be of urinary origin but looked like common stones. Viewing of the video provided by the father showed the patient surrounded by a crowd, and after visually apparent straining, a stone was passed per urethra. According to the father, the bizarre and frequent nature of these events piqued local interest, and gatherings during such incidences to see the event had become commonplace.

The mother displayed an overt interest in the underlying cause of her child's illness, and seemed eager for further investigations to be carried out. The

patient's father often worked away from home for prolonged periods of time and would return home late at night.

Further probing lead to increasing amounts of suspicion with regards to the mother, as she seemed highly indifferent to her child's suffering. Furthermore, most of these events occurred in the absence of the father. Her answers in relation to the child's medical history were inconsistent with information collected from the father or child, and details such as the feelings of confusion and wooziness experienced by the patient before passing a stone were ignored and not mentioned, presumably due to their highly suspicious nature.

According to the father, he and his wife had a normal, healthy relationship and had known each other for a long time prior to marriage. He had not experienced any happenings or erratic behaviour from his wife in the past and their previous medical history was largely unremarkable and not suggestive of mental disease or events similar to the case in question.

As the information collected from the parents and the child, and the evidence presented (Figure 1) were highly suggestive of MSBP, the parents were confronted and questioned regarding the patient. The mother vehemently denied any involvement in the case, but seemed unusually calm when accusations were levelled against her, denying any involvement. The child when questioned in isolation also denied recalling suffering any abuse at the hands of his mother but placed an emphasis on not recalling events prior to passing a stone.

In light of the evidence pointing to MSBP, upon explaining the case to the father, he was deeply concerned and was visibly shocked regarding the suggestion of the involvement of the mother, reiterating that he had not seen any behaviour from his wife that would suggest she was abusing their child.

The mother was referred to psychiatric care, and it was suggested that the child live with relatives for a period of time. A follow up a month later showed the patient had not experienced any such event while away from his mother, and the passing of stones had ceased. As seen in many cases of MBSP, a combination of evidence consisting of the aforementioned ceasing of the passage of stones when the patient was isolated from his mother, along with other evidence such as the stones presented being common stones and information collected during the history taking procedure confirmed the diagnosis of MSBP. It was hypothesized that the mother was premeditatedly and systematically administering sedatives to the patient, after which she would forcibly insert stones into his urethra which would be passed into the urine when the child gained consciousness.

The patient eventually returned to domiciliary care in the presence of the mother, and did not experience any problems thereafter. The father decreased his working hours, and took a more active participation in the upbringing of the child.

Figure-1: stones, large variation in shape, size and colour

DISCUSSION

First described by R. Asher[7] in 1951, Münchausen Syndrome is a disorder in which patients exaggerate or fabricate medical conditions with regards to themselves to gain attention and sympathy from health care workers or friends and family.

An extended form of Münchausen Syndrome, known as Münchausen Syndrome by Proxy (MSBP) was first described by R. Meadow in 1977[1], which is set apart from Münchausen Syndrome by the peculiarity that disease and disorders are induced or emulated in another individual, to meet the same ends, usually by care-givers. Victims are often under 6 years of age.

In 1994, the Diagnostic and Statistical Manual of Mental Disorders labelled the condition under a new terminology, referred to as Factitious Disorder by Proxy, which is synonymous with MSBP.[8]

The most common disorders fabricated by care-givers include failure to thrive, allergies, asthma, vomiting, seizures and diarrhoea.[9]

The diagnosis of MSBP can be a source of confusion for physicians, as during routine history taking procedures, information derived from care-givers is usually taken as de facto evidence of complaints experienced by paediatric patients. Suspected cases of MSBP therefore present a perplexity to physicians, as in order to exclude organic diseases which may be causing the complaints, investigations must be performed, some of which may be potentially injurious to the child, which is often a contribution the care-giver seeks and

desires.[10] The diagnosis of MSBP often relies on vigorous examination of the case in question, as usually signs and symptoms are entirely absent (when fabricated) or confusing and inconsistent (when induced). In either case, suspected cases of MSBP should be approached with utmost caution as misinterpretations and incomplete investigations of such cases have often lead to legal issues.[11]

Diagnostic indicators which are of assistance in clinical practice are usually related to the characteristics of the disease process under observation. The complaints will usually be prolonged and repetitive. Care-givers will often visit multiple physicians, and change them often. Investigations are usually inconsistent with descriptions of the complaints or a gross aberration may be visible[12], such as in our case, in which the stones were not calculi of urinary origin, but rather common stones picked from the ground and forcibly inserted into the urethra of the child to emulate the disease.

One of the most important indicators of MSBP is the disorder only occurs in the presence of the care-giver. **(12)(10)** When a child is placed under strict observation, the disorder largely vanishes. In such cases, it is important to note the number of visits made by the care-giver and the duration of time spent with the patient if the disorder recurs.

Care-givers of patients are usually calm, and do not seem overly concerned with difficulties being experienced by the child due to their disorder but seem to be deeply interested in the presenting complaints and following investigations being performed. They often have a history of child abuse and/or child deaths in the family or have signs and symptoms that correlate with the complaints attributed to the child. Demographically, studies suggest that in 90% of cases of MSBP, the mother is the abuser, in the remaining cases; a female care-giver is involved. Rarely, fathers or male care-givers are the abusers, and a few such cases have been seen in the literature.[13] Investigation of MSBP therefore involves studying the medical history of both the child and the care-giver to look for evidence of similar complaints occurring in the past. As care-givers usually change physicians often, previous physicians and other health care workers that have come in contact with the care-giver should be contacted and involved in the process. Aberrant initial investigations may lead to the diagnosis on their own, as they are often inconsistent, or unexplainable as occurred in our case. In many cases, video surveillance, home visits and isolation of the child from the care-giver is usually recommended and helps reach an accurate diagnosis.[3]

Treatment varies with regards to the degree of abuse involved. A mother who has simply suggested a child undergoes unnecessary investigations or treatments which are not of a serious nature can be confronted directly, and if cooperative, psychiatric treatment can be undergone with the patient staying at home. When cases involve highly damaging acts such as suffocation or poisoning, in which harm or death of the victim is likely, child protective services should be mandated, the authorities should be contacted regarding the case and the child should be placed in permanent out of home care.[3]

It is important to note that cases of MSBP are rare. Most mothers wish the best for their child, and provide accurate information to propagate quick and effective treatment procedures. However, the rarity of the disease should not be a factor in exclusion of MSBP and awareness should be raised with regards to this disorder when the diagnostic factors are in multitude and MSBP is highly suspected.[10]

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