

A variant of Munchausen syndrome presenting as a gynaecological emergency

Introduction

Munchausen syndrome is a rare disorder in which the patient presents repeatedly seeking medical care for factitious illnesses (Wise and Ford, 1999). In the original description in the *Lancet* (Asher, 1951), the patient showing the syndrome was admitted to hospital with an apparent acute illness supported by a plausible and dramatic history. Usually the history is largely made up of falsehoods; the patient is found to have attended and deceived an astounding number of other hospitals and nearly always discharges him-/herself against advice after quarrelling violently with both doctors and nurses (Asher, 1951). It is a complicated and intriguing

problem in medicine, and in obstetrics and gynaecology in particular.

Discussion

Various presentations of factitious diseases such as cardiac Munchausen (cardiac fantastica) (Park et al, 2004), neurological variants (neurologica diabolica), bleeding type (haemorrhagica histrionica) and Munchausen by proxy have been reported (Aleem and Ajarin, 1995) but presentation in a gynaecological emergency department with non-human specimens as the products of conception after a miscarriage is rare. Most doctors will encounter at least one patient with factitious disorder during their time in clinical practice, of which Munchausen syn-

drome is the most extreme type (Aleem and Ajarin, 1995; Falagas et al, 2004).

Factitious disorders are described in the literature as a broad spectrum of physical and/or psychological symptoms and signs, which are invented by the patient who intends to gain the sick role. These patients do not suffer from authentic psychiatric disease, but these patients are usually people who were deprived of love and care when they were children, with narcissism and other self-image disorders, who sometimes satisfy their masochistic tendencies via operative procedures. The majority of patients with Munchausen syndrome have a high IQ and deceive physicians who believe that they are investigating an actual disease (Aleem and Ajarin, 1995). A doctor in any speciality may face the problem of a factitious disorder at some time in his/her career and the risk of missing the diagnosis is considerable.

Factitious disorder is divided into three subtypes:

1. Predominantly psychological signs and symptoms
2. Predominantly physical signs and symptoms (Munchausen syndrome)
3. Combined psychological and physical signs and symptoms.

The characteristic presenting features of these syndromes are listed in *Table 1* (Aleem and Ajarin, 1995; World Health Organization, 2007) and the consensus is that these features are essential in recognizing Munchausen syndrome.

A high index of suspicion is therefore necessary whenever a patient shows any of the above features. In the case presented, the essential features of pseudologia fantastica and recurrent, feigned or simulated illness were present in addition to the sup-

Case Report

A 42-year-old woman presented to the accident and emergency medicine department and was triaged to the gynaecological emergency unit with vaginal bleeding and incomplete miscarriage of 13 weeks' gestation, which she brought in as a 'specimen of products of conception', following a miscarriage at home, in a plastic bag.

Her last menstrual period was on 11 December 2005, which made her about 13 weeks' gestation by date. She had three children and had had 'three miscarriages' previously. Her periods were regular, bleeding for 4–6 days in a regular cycle of 26–28 days. She had two 'positive pregnancy tests' at home but had never had an ultrasound scan before presentation. In her three previous miscarriages, there was no documented evidence of pregnancy either by a positive pregnancy test, elevated beta human chorionic gonadotrophin level, ultrasound scan findings of intrauterine pregnancy, whether viable or non-viable, or histological evidence of products of conception.

She looked very distressed but her general physical examination was normal and her vital signs were within normal limits. Pelvic examination revealed minimal blood in the vagina and the cervix looked normal, but patulous. The uterus felt slightly bulky in size and mobile.

An intravenous line was put up and blood taken for full blood count, C-reactive protein, grouping and saving serum, and serum beta human chorionic gonadotrophin estimation, and a pelvic ultrasound scan was arranged.

The need for hospital admission was explained to complete the investigations and initiate appropriate management. She was also prescribed a course of antibiotics and analgesics.

The specimen, which was in the early stage of decay, was inspected and found to be offensive. It was sent in formalin to the histopathology department for histology.

The patient refused admission into the gynaecological ward and also a transvaginal ultrasound scan which had been arranged. She signed the discharge against medical advice form in spite of advice to the contrary.

Further inquiry of her GP confirmed that she had had treatment for depressive illness in the past and has changed her GP frequently, making it difficult to arrange effective follow-up. The GP promised to arrange psychiatric assessment as soon as practicable.

It was not known at this stage that she was not actually having a miscarriage and that the purported products of conception were in fact chicken giblets.

Dr Stephen EO Ogbonmwan is Post CCST Fellow and **Mr Kenny Abidogun** is Consultant in the Department of Obstetrics and Gynaecology, The Royal Bolton Hospital, Bolton

Correspondence to: Dr SEO Ogbonmwan, clo BJHM

Table 1. Diagnostic features of Munchausen's syndrome

Essential features	Pathological lying (pseudologia fantastica)
	Peregrination (travelling or wandering)
	Recurrent, feigned or simulated illness
Supporting features	Borderline and/or antisocial personality traits
	Deprivation in childhood
	Equanimity for diagnostic procedures
	Equanimity for treatments or operations
	Evidence of self-induced physical signs
	Knowledge of or experience in a medical field
	Most likely to be male
	Multiple hospitalizations
	Multiple scars (usually abdominal)
	Police record
	Unusual or dramatic presentation

From Aleem and Ajarin (1995); World Health Organization (2007)

porting features of multiple hospitalizations, unusual or dramatic presentation, evidence of self-induced physical signs and maternal age of 42 years.

The patient presented with a complaint of vaginal bleeding and having passed products of conception which she brought to the hospital in a plastic bag. She was accompanied by her son who showed genuine concern for his mother. The ease with which she gave her 'history' to the attending emergency room gynaecologist indicates that this patient may have had an underlying long-standing personality disorder.

She refused hospitalization and other appropriate investigations that were necessary to confirm her diagnosis and initiate appropriate treatment. In other presentations, patients allow themselves to be subjected to all investigations including surgery, especially in the abdominal type (laparotomophilia migrans) (Folks and Freeman, 1985). On looking at her case records, however, this patient had had repeated surgery to her right wrist for chronic joint pain. It may be possible that the primary aim of this case was medical attention rather than hospital admission. This seeking of medical attention may be a neurological behaviour of dependency on doctors (Carney and Brown, 1983).

Krahn (2003) reviewed 93 patients and found that 67 (72%) were women and the

mean age was 30 years. Health-care training or jobs were more common for women (65%) than men, and most (80%) had early psychiatric consultation. This patient had had treatment for depressive illness in the past as per the GP's record although there was no history of a previous health-care job.

In the 19 cases reviewed in the obstetrics and gynaecology literature (Edi-Osagie et al, 1998), there was no presentation as seen in this case. Although there were cases of irregular vaginal bleeding, none was as dramatic as bringing pseudo-products of conception into the gynaecological emergency unit. Is this therefore a variant of gynaecological Munchausen syndrome?

In a typical patient with Munchausen syndrome, onset of the disease is usually in early childhood often after hospitalization for a physical illness (American Psychiatric Association, 1994). In the case presented, it is possible that the problem may have persisted for a long time until the diagnosis was made after the alert from the histopathology report, which showed the patient actually brought chicken giblets as her products of conception. The patient had visited the accident and emergency department with spurious complaints on 26 occasions in 5 years from her computer record. Similar visits were made to her own GP for different ailments and she had had repeated surgeries to her right wrist.

There is minimal information on the available treatment of Munchausen syndrome. Insight-oriented psychotherapy and behavioural modification have shown marginal success (Folks, 1995) so this patient was referred for psychotherapy via her GP. The main aim will be to focus on identification and prevent further hospital presentation, further unnecessary and expensive sometimes-risky medical investigations and treatment (Highland and Flume, 2002). It is thought that publishing these cases will help protect these patients from injurious consequences of their disease, protect physicians and hospitals from 'deception' and the community from substantial costs of their care, especially in this era of patients' rights and defensive medical practice (Rabinerson et al, 2000). **BJHM**

The authors would like to acknowledge the histopathology department of the Bolton Royal Hospital for alerting them to the histological nature of the specimen.

- Aleem A, Ajarin DS (1995) Munchausen syndrome presenting as immunodeficiency: a case report and review of literature. *Ann Saudi Med* **15**(14): 404–6
- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders*. 4th edn. American Psychiatric Association, Washington DC
- Asher R (1951) Munchausen's Syndrome. *The Lancet* **i**: 339–41
- Carney MW, Brown JP (1983) Clinical features and motives among 42 artificial illness patients. *Br J Med Psychol* **56** (Pt 1): 57–66
- Edi-Osagie EO, Hopkins RE, Edi-Osagie NE (1998) Munchausen's syndrome in obstetrics and gynecology: a review. *Obstet Gynaecol Surv* **53**(1): 45–9
- Falagas ME, Christopoulou M, Rosemarakis, ES, Vlastou C (2004) Munchausen's syndrome presenting as severe panniculitis. *Int J Clin Pract* **58**: 720–7
- Folks DG (1995) Munchausen's syndrome and other factitious disorders. *Neurol Clin* **13**: 267–81
- Folks DG, Freeman AM (1985) Münchhausen's syndrome and other factitious illness. *Psychiatr Clin North Am* **8**: 263–78
- Highland KB, Flume PA (2002) A "story" of a woman with cystic fibrosis. *Chest* **121**(5): 1704–7
- Krahn LE (2003) Patients who strive to be ill. Factitious disorder with physical symptoms. *Am J Psychiatry* **160**: 1163–8
- Park TA, Borsch MA, Dyer AR, Peiris AN (2004) Cardiopathia fantastica: the cardiac variant of Munchausen syndrome. *South Med J* **97**(1): 48–52
- Rabinerson D, Kaplan B, Orvieto R, Deael A (2000) Munchausen syndrome in obstetrics and gynecology. *J Psychosom Obstet Gynecol* **23**(4): 215–18
- Wise MG, Ford CV (1999) Factitious disorders. *Prim Care* **26**: 315–26
- World Health Organization (2007) *International Statistical Classification of Diseases and Related Health Problems*. 10th Revision. World Health Organization, Geneva (www.who.int/classifications/apps/icd/icd10online accessed 5 June 2008)