ABSTRACT

The management of Munchausen syndrome is fraught with complexities related to legality, ethics, and its inherent nature. An illustrative case of factitious aortic dissection is presented as well as a review of the literature for the management Munchausen syndrome, which includes strategies reported to be effective. Management of Munchausen syndrome requires a high index of suspicion, a good history, and thorough physical examination. Objective illnesses resulting from the factitious behavior should be treated, while avoiding unnecessary procedures. Early referral to a psychiatry team is critical as this may be an empathetic and face-saving approach for the patient. Regularly scheduled appointments, not dependent on the patient’s distress level, are associated with improved long-term prognosis. Patients with Munchausen syndrome can suffer considerable iatrogenic morbidity and mortality, and they place immense strain on the health care system. Physicians should be aware of the complexities of these cases, the management options, and the frequent need for psychiatry consultations [Psychiatr Ann. 2016;46(1):66-70.]

Munchausen syndrome is the most severe and chronic form of factitious disorder imposed on the self, with predominantly physical signs and symptoms, pseudologia fantastica, and peregrination (frequent traveling from one medical center to another) that often lead to recurrent hospitalizations. It tends to have a refractory course. Munchausen syndrome is unique because it is a psychiatric disorder that most frequently presents as an apparently severe illness in the non-psychiatric setting. Even though Munchausen syndrome is studied by most clinicians in training, the first case often leaves them feeling blindsided by the patient, creating a fractured clinician-patient rapport. Many clinicians remember their first Munchausen syndrome case as if they were seeing medicine through a distorted prism and struggle with residual conflicting thoughts, as the clinical and ethical implications can be challenging.

Munchausen syndrome was first described by Dr. Richard Asher in his landmark 1951 article. He had named the
syndrome after Baron Hieronymus Carl Friedrich Munchhausen (1720-1797), a minor nobleman who had joined the Russian army to fight against the Turks. He rose to the rank of cavalry man and retired to his estate in Bodenwerder, near Hanover, as a country gentleman in 1750. Rudolph Eric Raspe, possibly an acquaintance of the Baron’s, fled Germany for England when he was caught embezzling from a museum. To pay off debts, Raspe anonymously wrote several books, including an exaggerated account of the Baron’s tales, “Baron von Munchhausen’s Narrative of his Marvelous Travels and Campaigns in Russia,” which was published in London in 1778. The second edition was translated into German. The Baron was age 65 years when the German translation appeared, and he became an instant celebrity. He pursued several lawsuits unsuccessfully to protect his name, and died an embittered man. The irony in the naming of Munchhausen syndrome is that the Baron was simply an old gentleman who liked to spin yarns as after-dinner entertainment for his friends. The true villain was probably Raspe.

The psychopathology of Munchhausen syndrome is poorly understood, and its management is fraught with complexities related to legalities, ethics, and its inherent nature. Most published works consist of case reports, and there are no treatment studies. The aim of this article is to focus on management, which is often overlooked in the medical literature. A famous illustrative case from our medical center is included. This case of a patient with factitious aortic dissection is unique because it has been documented in the literature over a 10-year period, and yet the patient is still visiting doctors today seeking treatment. The second part of this article proposes a management approach that includes strategies reported to be effective.

ILLUSTRATIVE CASE

A 31-year-old man was admitted to the cardiothoracic surgical (CTS) intensive care unit of our teaching hospital after being flown in from a smaller hospital for a possible aortic dissection. At intake, he stated upfront that he had Ehlers-Danlos syndrome (EDS) type IV diagnosed by skin biopsy resulting in a traumatic aortic dissection in Germany in 2004. EDS type IV, also known as Vascular Type EDS, is the most severe form of this heterogeneous disorder and is associated with spontaneous rupture of medium-sized arteries, including the aorta. Type A dissections usually require surgery. The patient reported having a median sternotomy, and a family history of EDS in his mother and Marfan’s syndrome in his late father. He claimed to have had three acute myocardial infarctions (in 2004, 2005, and 2009). Moreover, he produced a November 2011 report of a trans-esophageal echocardiogram done at a Michigan hospital stating “Type A dissection.” He claimed surgeons said he was “too high risk to operate on,” but that he should go to a hospital if he developed chest pain. He also said he suffered a subarachnoid hemorrhage in 2002 due to cerebral aneurysm and he was recently diagnosed with bilateral femoral head avascular necrosis. He reported a long list of drug allergies including several pain medications, all purportedly causing anaphylactic reactions. He initially refused a magnetic resonance angiography (MRA) because of “aneurysm clips” after his “prior sternotomy.” Contrast computed tomography (CT) of the chest was contraindicated because of his reported allergy to the contrast dye. A noncontrast CT of the chest showed only standard postoperative mediastinal surgical clips, which are not contraindications to MRA. His MRA revealed no aortic dissection.

His medical history was very dramatic and inconsistent. He said he had extensive medical knowledge, requested to have no visitors, and he refused to give consent for us to contact his family. He said he lived with his mother in Iowa and that he was visiting “church members” in the region. He claimed that he had finished college and seminary school and that he had been working as a pastor for 14 years after starting as a “youth pastor.” He reported meeting his fiancé online, and although they had never met, they were engaged and planning to marry in 2 years. He denied having a psychiatric history. The medical and social histories were presented without any notable distress, with stable vital signs and without the murmur of aortic insufficiency. There were no clinical features of EDS type IV other than the claimed history of aortic dissection. The patient specifically requested central line placement under ultrasound guidance. He presented old medical records with signs of chronic handling, highlighted in several areas, without documentation of prior sternotomy, although he did have an appropriately placed scar. Our psychiatry consult team was contacted when the unique features of the clinical picture alerted the CTS team to the possibility of Munchhausen syndrome.

The patient’s story started unraveling when our CTS team contacted a major university medical center to discuss management options of this complex case, only to discover that this patient had presented there twice with similar complaints, background history, and the eventual diagnosis of factitious aortic dissection. We also learned that a case report of this patient had been published in 2006, with subtle variation in details. The report attracted two letters to the editor stating similar encounters at two other major heart centers, with one encounter at least 3 years earlier. This heart center cited multiple requests for transfer from other medical centers regarding this person. One other case report about this patient was found in another report’s bibliography that was not found in the initial literature search.

The literature confirms that this patient has presented to more than 100 hospitals along the east coast of the United States over the course of about 10 years,
and that he has succeeded in gaining costly evaluations, including a median sternotomy. He had incurred over $1 million in expenses, excluding physician reimbursement. These details demonstrate that even when Munchausen syndrome is strongly suspected, it is a risk to not investigate and almost impossible for physicians to forfeit proper evaluation for fear of missing real pathology, especially in this litigious age. These conflicts tend to create intense counter-transference in physicians encountering Munchausen syndrome, as they often perceive that their valuable time and efforts have been wasted. Inevitably, resources consumed by these patients delays care and uses resources needed for others with genuine pathology.

**MANAGEMENT OF MUNCHAUSEN SYNDROME**

Most physicians are uncomfortable diagnosing factitious disorders, of which Munchausen syndrome is the most extreme variant. Munchausen syndrome disrupts the normal physician-patient relationship, which is based on trust. When unmasked, Munchausen patients react in ways ranging from ambivalence to hysteria and denial of fabricating their illness. Adults often are reluctant to see psychiatrists and leave the hospital against medical advice. Children and adolescents, however, are more inclined to admit to their fabrications and are more inclined to agree to psychiatric follow-up.

The recurring theme in this review points toward maintaining a high index of suspicion, but when should a clinician begin to suspect Munchausen syndrome? What evidence can help determine the intentional feigning of disease? The first step is to complete a detailed history and physical examination, using repetition as a confirmation tool in the effort to identify biopsychosocial inconsistencies. Consistently reported clues include dramatic presentations; inconsistent histories; recurrent illnesses that worsen or change after appropriate treatment; extensive medical knowledge; knowledge of hospital systems; an eagerness for invasive procedures; claiming specific diagnoses; and attempts to dictate treatment. There may also be a previous history of Munchausen behavior, use of aliases, and peregrination. Lack of stable relationships is common as these patients may have a history of neglect during childhood, disruptive family ties, poor interpersonal relationships, and estrangement from their families.

Consequently, families are frequently unavailable for contact. Patients with Munchausen syndrome often have some medical training. However, in the Internet era with online scientific journals and disease-related web sites, patients no longer need much medical experience to engage in convincing disease fabrication. Appropriate tests should be done where indicated, as the diagnosis of Munchausen syndrome does require exclusion of real pathology. Reviewed 190 articles describing laboratory and other tools that could aid clinicians in recognizing induced illness. Clinical judgment is clearly required in striking a balance between avoiding unnecessary and potentially risky tests and procedures and the dangers of reflex dismissal of patients’ complaints, because genuine illness may be present.

Blacklisting, reporting of patients, and flagging in medical records have been suggested; however, this is controversial. It is evident that management must be based on objective signs and data, including corroboration of the patient’s history. It is notable that fatalities may result as a direct consequence of the patient’s factitious behavior. Once it is clear that the treatment team could be dealing with Munchausen syndrome, several different steps could proceed sequentially. Illness resulting from the patient’s factitious behavior should be treated. Due to the significant risks of unnecessary treatment, it is important to obtain outside medical records and to contact previous providers or family. When emergent care is required, performing a search of the room and personal belongings without patient consent may be justifiable. Patient observation may be required for protection from further self-harm and to provide evidence of fabrication. This includes use of sitters or 24-hour video monitoring. The hospital legal team can be consulted to address concerns. Family members may encourage litigation when the patient does not seem to recover, and the patient may agree to avoid admitting to the true etiology of their problems. However, patients with Munchausen often withdraw their case from litigation due to the fear that a court case would expose the true nature of their disorder.

It is consistently recommended that a psychiatry team be consulted as early as possible. The psychiatry team’s most important role is to help the primary treatment team manage the patient in the safest, most appropriate way, which includes setting compassionate but firm limits and steering the patient toward psychiatric care in an empathic and face-saving nonconfrontational manner. Patients may react to confrontation with symptom escalation to substantiate the legitimacy of their needs, putting themselves at risk for more self-harm. Psychiatrists also have an important role in managing counter-transference and helping health care staff realize that these patients have severe psychiatric problems that are driving their medical fabrications. Many patients with Munchausen syndrome have histories of parental neglect, childhood abuse, early losses, early illness that led to prolonged medical treatment or hospitalization, recent life-stressors, poor family relationships, poor cop-
ing skills, and attention and sympathy seeking in addition to repeated medical admissions at various medical centers without resolution of their symptoms. Comorbid personality disorders are common. For others, Munchausen syndrome could be a means to control others, express rage, or enhance their self-esteem as they succeed in deceiving clinicians.

Patients with Munchausen are often refractory to psychotherapy, although there are reports of success. Flexible, creative approaches that emphasize consistency and regular psychiatric outpatient follow-up appointments independent of the patient’s reported distress levels are associated with the most success. Regularly scheduled appointments with primary care physicians that are not dependent on medical crises also have been shown to provide object constancy while minimizing the need to fabricate illness to seek attention. Regularly scheduled appointments provide support that does not threaten patients’ self-esteem, as well as a basis for developing a trusting doctor-patient relationship. Having a stable support system with an ability to form and maintain relationships is associated with better prognosis. The primary care physician can be the gatekeeper that approves the tests and procedures recommended by specialists. If the patient’s family can be involved, they may be encouraged to pay more attention to the patient and less to the illness symptoms, and support the patient’s requests for additional services and requests to accompany them to the hospital. In addition to treating psychiatric disorders, psychopharmacotherapy and behavioral strategies such as double-bind techniques, have been described in treating specific factitious dermatologic conditions. Low-potency antipsychotics have been effective in managing dermatitis artefacta.

CONCLUSION

Patients with Munchausen syndrome may suffer considerable iatrogenic morbidity and mortality. They also place significant strain on the health care system. It is important for clinicians to include Munchausen syndrome in the differential diagnosis of difficult cases where there is an abundance of conflicting medical history details in patients with an unusual knowledge of medicine. Clinicians need to be aware of the management options and approaches for patients with Munchausen syndrome to avoid contributing to iatrogenic pathology. Although prognosis is poor, every patient with Munchausen syndrome should be given a chance for recovery, as the literature does include some successful treatment outcomes.

REFERENCES

28. Williams TD, Vieira S, de Fátima Avila L. Interesting case: factitious illness (Munchau-
64. Imrie FR, Church WH. Factitious kera-toconjunctivitis (not another case of ocular Munchausen’s syndrome). Eye (Lond). 2003;17:256-258.