Munchausen syndrome by proxy: a case report

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Munchausen syndrome by proxy (MSBP) is a serious form of child abuse, which is characterized by a child with symptoms and signs of an illness that have been fabricated by the mother. Here, we present a case of MSBP, who at four months of age was brought to our hospital by her mother because of rectal bleeding. The patient underwent many invasive procedures until the diagnosis of MSBP was finally considered. The mother reported no rectal bleeding for almost a year, during follow-up at the well-child outpatient department. At 19 months of age, another episode of rectal bleeding occurred, when a bloody diaper was presented to the attending physicians. The blood group and DNA analysis of the blood in the diaper confirmed the diagnosis. The case was reported to the social services and the patient was placed in the custody of her father's sister. The mother is still undergoing treatment in our psychiatry department.

Key words: Munchausen syndrome by proxy, factitious illness, rectal bleeding.

Munchausen syndrome by proxy (MBSP), first described by Meadow[1], is a serious form of child abuse which is characterized by a child with symptoms and signs of an illness that have been fabricated by an adult, usually the mother. Fabrication of those signs and symptoms lead doctors to perform many unnecessary and painful investigations and treatments on the child. The victims are usually under six years of age[2]. These are difficult cases to manage and the condition may result in the death of the victim. In the ones who survive, as they grow older, there is a tendency to participate in the deception and to believe that they are disabled[3].

The awareness of medical staff about child abuse is a new emerging concept in Turkey[4] and MSBP, being a special form of child abuse, is unknown by many physicians. We aim to call attention to the disease in our country, by presenting a case of MSBP. To our knowledge this is the first reported case in Turkey.

Case Report

G.E., now a 21-month-old girl, had been brought to our hospital approximately 1.5 years previously due to rectal bleeding. At four months of age, her mother, claiming passage of a bloody stool, brought her to the emergency department at 11:30 p.m. Physical examination was unremarkable except for a small anal fissure. A complete blood count, stool examination including cultures and abdominal ultrasonography revealed normal findings. The rectal bleeding was thought to be due to the anal fissure and the patient was sent home with appropriate recommendations. During the next three months, she was brought to the emergency department every two-three weaks, mostly at nighttime, with the same complaint. Because of the recurrence of the complaint, she was admitted to the pediatric ward for observation and investigation. All of the haematological values including complete blood count, ferritin, prothrombin time, and activated partial thromboplastin time were within normal limits. There was no occult blood in her stool. A radionuclide scan for Meckel's diverticulum was negative. Gastrointestinal system endoscopy and biopsy revealed normal findings. Radiographs of small and large bowel were normal and she was subsequently discharged. Fourteen days after her discharge, when she was seven months old, she was brought to the emergency room at 10:30 p.m. This time her mother supplied a diaper soiled

with blood, as hard evidence for rectal bleeding. Physical examination revealed the presence of a small amount of blood in her perineum, but no sign of injury was evident around her vagina or anus. She was readmitted for observation. During the hospital stay the mother appeared suspicious, because of her exaggerated willingness to let her baby undergo medical investigations, while being completely indifferent to her suffering. She explained that this was her second marriage and G.E. was her fourth child. Complaining about her current husband, she characterized him as an alcoholic. She claimed to have experienced domestic violence in her previous marriage, with her three previous babies dying around 8-10 months of age with similar symptoms. She expressed difficulty remembering their exact age of death, as well as the given diagnoses and even their names. When asked to present their medical records, she replied that this was impossibile, as they were destroyed by the recent earthquake in Adapazarı State Hospital. Her indifference alarmed the staff. Moreover, there were many inconsistent points in her story about times and places. Although claiming to be a police officer, investigations revealed that she actually was a housewife. An intern remembered her undergoing an appendectomy the previous years. Her file indicated that she was readmitted two days after her discharge and remained in hospital for another month because of wound infection, which failed to improve despite appropriate treatment. The intern further added that her physicians had assumed that she had intentionally infected herself. These facts led to the consideration of the diagnosis of MSBP.

The baby was moved to the intensive care unit to separate her from her mother. A psychiatric consultation was obtained concerning the parenting behavior of the mother. During the three psychiatric interviews, one of which included her husband, then most prominent feature was the inconsistency in both the personal history of the mother and the disease of her child. The content of her personal information including her own developmental, educational, marital, parental and professional history, was highly variable. When she was slightly confronted with these discrepancies, she managed to find new explanations without any sign of anxiety, which in turn were not compatible with the previous history. Psychometric tests including MMPI and Rorschach did not reveal any gross psychopathology, except for a tendency for somatization and depressive features, together with a defensive pattern.

Her husband appeared nervous and irritable about the interview and was highly uncooperative. He also had a defensive pattern about their marriage and about his wife, and was unwilling to volunteer clear information concerning the issues at hand. He denied any addiction or problems regarding alcohol consumption and refused further treatment. The case was reported to the social services. A home visit was performed, where the living conditions were found far from satisfactory, the flat being dirty and smelling of alcohol.

The baby was observed in the hospital for 15 days without subjecting her to any invasive procedure. During this time she was separated from her mother for three days while she was kept in the intensive care unit. Otherwise she stayed with her mother in a regular hospital room, with three patient beds that prevented the mother's remaining alone with her child. No rectal bleeding was observed during her hospital stay. At the time of discharge, the mother was informed that no organic disease could be found in the baby, but that she would be followed closely in the healthy children outpatient department. She was urged to feel free to consult her daughter's physicians whenever there was a problem, in order to discourage her from seeking medical attention elsewhere. Consequently she was followed by monthly visits for a year. The mother denied any problems including rectal bleeding. Normal developmental milestones were reached.

At 19 months of age, her mother, citing a large amount of rectal bleeding, brought G.E. to the emergency room one night at 01:00 a.m. Although a diaper with bright red, unclotted blood was presented, the baby looked healthy and her hemoglobin level was normal. The blood in the diaper was tested for blood type and was found to be 0 RH (+), while the baby's blood group was A Rh (+). This incompatibility was confirmed by the criminology laboratory, which revealed that the DNA analysis of the blood in the diaper was different from the patient's blood. This last incident confirmed the diagnosis of MSBP.

The mother was confronted with the situation. She remained calm and defended herself by pointing out that she was not responsible, but that her husband or mother-in-law might have tried to mislead the physicians. When she was told that her baby would be kept in the hospital until the situation was resolved and that social services would then decide on the future of the baby, she exhibited no emotional response. On the other hand, the father displayed disbelief and anger. He menacingly referred to his wife's previous operation and wound infection, and blamed the physicians for the still more ineffective handling of the child's illness. He accused them of treating his wife as a psychotic and himself as an alcoholic. He insisted that her daughter should be immediately discharged and refused to contact the social services, but later changed his mind and was persuaded to do so. The social services decided to put the child under custody of her father's sister. The mother was admitted to the psychiatry ward, where she confessed that she created the entire scenario about the rectal bleeding of her daughter. She said that it was her own menstrual blood in the beginning, but in the last incident she used a tube of blood she found in the hospital. According to her, the reason for this fabrication was a dysfunctional family life. She accused her husband of drinking alcohol, and of abusing her physically when he was drunk. She related that she needed to go out of the house whenever there was a quarrel with her husband, and found the hospital a safe enough environment to escape to.

Discussion

Asher[5] coined the term Maunchausen syndrome in 1951, in his description of patients who consistently produced false stories or symptoms about themselves to obtain needless hospital investigations and treatments. In 1977, Meadow[1] described another form of this syndrome where the parents, usually the mother, caused their children to undergo harmful hospital procedures by fabricating symptoms, which was called Munchausen syndrome by proxy. Since then, many cases have appeared in the literature[6-8].

The most common presentations seen in MSBP include any form of bleeding (hematuria, hematochezia, hematemesis, etc), seizures, central nervous system (CNS) depression, apnea, diarrhea, vomiting, fever and rash[9,10]. Our patient was brought to us with one of the most common presentations of MSBP, namely gastrointestinal bleeding. While this symptom justifies the mother's taking the child to the emergency room and is easy to fabricate, it presents a dilemma for the attending physicians, due to the fact that in order to exclude organic disease, invasive procedures must be ordered. The medical personnel contribute indirectly to the damage inflicted, by resorting to painful investigative procedures as experienced in our case up until her fifth admission.

There are some specific features of MSBP which lead to the correct diagnosis[11,12]. First, the illness is prolonged, unexplained and repetitive; observations and investigations are inconsistent with parental reports or the condition of the child. In our case, although the mother brought the baby to us every 2-3 weeks for almost 1.5 years with the complaint of rectal bleeding, the baby looked unusually healthy for a child bleeding so massively. All investigations performed to find the etiology of the bleeding were normal. Second, symptoms and signs begin only in the presence of the mother. They are conspicuously absent when the baby and mother are under strict supervision. In our case, the mother was the only witness of the bleeding. Others saw only the bloody diaper she presented. When the baby stayed in the hospital and when they were under supervision, there was no bleeding reported by the mother. Third, mothers are unusually calm for the severity of illness and not as worried as the nurses and doctors about their child's illness. Our patient's mother was very eager to stay in hospital, but she looked as if she had no anxiety about her baby's illness. She accepted every invasive procedure for her baby without any sign of worry. Fourth, there is a history of unexplained or unusual illness or death in previous children. Our mother had a very similar story that could not be confirmed, due to the unavailability of either birth or medical records of these babies. As no records were available, this information was supposed to be a part of the scenario fabricated by the mother to convince the doctors about the gravity of her daughter's illness. Fifth, more than half of the mothers have some features of Munchausen syndrome themselves[9]. The hospital records of the mother revealed an unusually prolonged wound infection after

appendectomy. However, her surgeon believed that the wound had been infected intentionally. Sixth, the fathers are usually extremely unsupportive of their wives and unaware of the fabrication of the illness[9]. Our patient's father abused alcohol. The mother admitted that she was an unhappy woman. In their last presentation to the emergency room, she stated that she had left her husband because he was drinking too much, but later had been persuaded by him to come back with a promise to cease drinking.

Some authors classify such mothers into three groups: active inducers, help seekers and doctor addicts[13]. The first group actively induces the symptoms in their children. Help seekers have social problems such as domestic violence, unhappy marriage, etc, and they use their children to avoid these problems. They are more open to psychotherapeutic intervention. The third group, doctor addicts, being more antagonistic, suspicious and paranoid, are obsessed with the goal of obtaining medical treatment for non-existent illnesses of their children. The mother of our case was classified as a "help-seeker", taking into consideration her relation with her alcoholic husband. We believe that our concern about her problems and the psychological support we provided helped her to deal with them for almost one year.

The patients with MSBP usually do not show a gross psychopathology as in this case. Proposed explanations for the illness behavior in MSBP remain to a large degree speculative. The underlying motivations for this disease are probably heterogenous and multifactorial. Expect for the search for nurturance, secondary gains, and the need for power and superiority, it is proposed that the patient with a poor sense of self can achieve a personal identity with the sick role and the pseudologia phantastica (pathological lying). The predominant feature of the mother of our patient was also pathological lying. She described herself as a police officer in the hospital and gave a history of loss of three children. The latter was serving her needs by making her doctors assume that they were faced with an unusual case of bleeding, resulting in increased attention to the baby; while the former was helping her to create the sense of identity in which she was no longer an abused wife with lifelong difficulties, but a working lady with a sick child, deserving the care of the hospital staff.

To confirm the diagnosis of MSBP, some authors recommend the use of a covert video surveillance[14], while others claim that it is unethical and should be used only in restricted circumstances[15]. We preferred to separate the mother and child or to keep them under close supervision instead of video surveillance. If the symptom of MSBP is bleeding of any origin, it is suggested to examine the blood group in the specimen[16]. In our patient, the blood grouping and DNA analysis of the blood in the diaper confirmed the diagnosis.

The management of MSBP consists of confronting the mother. Many cases respond to that kind of therapy[11]. The aim of the confrontation is to understand and respect the meaning of the symptoms in order to help. In our case, after the diagnosis was firmly established, the mother was confronted and was admitted to the psychiatry ward, where she is still under treatment. During the mother's hospitalisation period, her husband also accepted treatment. Another approach is to separate the child from the family by placing her under custody. This is especially recommended in more dangerous situations, where the abuse involves suffocation or poisoning, the child is under five years of age, or there is a history of sibling death or overt Munchausen syndrome in the mother herself[17,18]. Because our case fulfilled most of these criteria, she was reported to the social services. Interviews with all the members of the family were obtained that led to the decision to place the infant in her aunt's custody. She has been living with her aunt's family for three months now and feels safe and happy with them. After psychiatric treatment of the mother, family reunification has been tried for certain cases, but long-term follow up is necessary to ensure the child's safety[19].

Most of the mothers we meet during our practice tell the truth about their babies and their observations are very valuable. We must listen to them carefully and act accordingly, but rarely we may meet such mothers who try to deceive their physicians. If our aim is to supply a good quality of life to all children, we must be careful in the situations listed below:

- Prolonged or recurrent symptoms and/or signs which are irrelevant to patients' general health state and cannot be explained by medical professionals.

- When the mother is the only witness of the symptoms and the symptoms and/or signs disappear in the absence of the mother.
- Admissions of other children within the same family with similar features.
- Unexplained child loss within the same family.
- Mothers who are unusually calm about the illness of their children and eager to let their children undergo invasive procedures or hospitalizations.
- Mothers with unexplained physical or psychiatric diseases, symptoms or signs.

In such cases, the diagnosis of MSBP should be considered before performing invasive procedures on the child.

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