Family Practice Grand Rounds

Munchausen Syndrome: A Dilemma for the Family Physician

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DR. RAYMOND O. WEST *(Professor of Family Medicine, Coordinator of the Affiliated Family Practice Network)*: Baron Heironymus Karl Friedrich von Munchausen never anticipated that his name would gain an added measure of fame as a medical eponym. Although a German nobleman, he fought as a cavalry officer in the Russian army during the Russo-Turkish war of 1736-1739. Later, he became a brilliant raconteur, delighting European society with exaggerated tales of his exploits as a soldier and horseman. His stories were boldly embellished by Rudolf Raspe[1] in 1785, who portrayed him as a weaver of preposterous fabrications. In 1951, Asher[2] coined the term "Munchausen's Syndrome" to describe a disease characterized by the presentation of "apparent acute illness, supported by a plausible and dramatic history" but composed largely of falsehoods. Other writers, apparently preferring less whimsical names, have called it chronic factitious illness,[3] hospital addiction syndrome,[4] and peregrinating problem patients.[5] None of these has taken hold, so Munchausen syndrome it is.

The condition presents a number of difficult challenges to family physicians: first, early detection; secondly, differential diagnosis from conversion hysteria, masochism, malingering, and other entities; thirdly, management and treatment of the patient; and fourthly, protection of the hospital and the physician from undue exploitation.

The syndrome can take on any number of presenting symptoms. The most common were covered by Asher[2]: acute abdominal, hemorrhagic, and neurological problems. Others, more recently described, include factitious fever by manipulation of thermometers[6] or self-injection of substances,[7] simulated neurological emergencies made plausible by self-administration of anticholinergics,[8] feigned bereavement,[9] and clever simulation of psychiatric symptomatology.[10] Simpson[11] noted that feigned bereavement, often amplified with poignant detail, is particularly characteristic of Munchausen syndrome.

Some physicians hesitate to confront patients with their deceptions because many such persons simply flee, only to surface again at another time and place. Stone[12] and Ferguson and Maki[7] take the contrary view. They believe that persons possessing sufficiently integrated personalities should indeed be confronted, followed by concerted efforts to get them to undergo psychotherapy.

According to Sale and Kalucy,[13] the key to proper management is early detection to preclude potentially hazardous surgical procedures. Yassa[14] reported successful treatment of one patient with a long-term regimen of psychotherapy, psychosocial counseling, and positive reinforcement behavior modification.

Ferguson and Maki[7] caution against the sometimes popular idea of blacklisting the Munchausen patient, warning that although it might be convenient for the provider, it is unwise and potentially dangerous for the patient. Remember, it is an extremely serious disease, life threatening in that patients frequently mutilate themselves and are at high risk of suicide.

With this introduction, Dr. Tilton will describe

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0094-3509/80/110803-06$01.50

the case of a rather remarkable woman. Let us decide for ourselves whether Munchausen syndrome is an appropriate diagnosis for her condition.

DR. BERNARD E. TILTON *(Professor of Pharmacology, Assistant Professor of Family Practice)*: Our patient is a 55-year-old Caucasian woman who entered the hospital with complaints of fatigue and weakness for several weeks; she also complained of abdominal pain and mass for seven days. She had been in poor health since early childhood. Her immediate problem began on the afternoon of admission. While shopping, she became weak, blacked out, and was taken to a community hospital, where the laboratory reported a blood glucose of 400 mg/100 ml. She was admitted with a preliminary diagnosis of uncontrolled diabetes complicated by drug and alcohol abuse. Diabetes had first been diagnosed some 12 years ago; until recently she had taken chlorpropamide (Diabinese). About two weeks before her admission, a resident at another hospital directed her to discontinue this oral medication. She claims to have been careful with her diet, avoiding salt and eating only about 700 to 1,200 calories daily. She checks her urine once or twice a day and sometimes finds glucose. On this point, she was a bit evasive; perhaps she is less careful than she would have us believe.

She had not been well since her discharge from another hospital ten days earlier, following surgery for placing a vena caval grid to prevent thrombotic emboli. The abdominal mass was the problem that really concerned her; she feared it would require more surgery.

Past pertinent history included incarceration for $2^1/_2$ years during World War II in concentration camps in Belgium and Germany, where she received a serious head injury, lost her father, and was exposed to severe mental stress. Persistent troubles began about 1946 when she was in Walter Reed Hospital for 14 months. She admits to a tonsillectomy at that time but such a long stay would more likely suggest a psychiatric problem. In 1948, she had three operations for hydronephrosis and in 1949 underwent a right mastoidectomy. A platinum plate was placed in the right parietal area of her skull for reasons related to the head injury. She had thrombophlebitis on five separate occasions. In 1963, she underwent a hysterectomy with a bilateral oophorectomy which she claims was followed by pulmonary embolism. In 1964, she had a cholecystectomy. In 1971, she had a cystocele repaired, allegedly for the fourth time, but she could not remember the earlier dates. In 1972, she had a neuroma removed from her right foot and oral surgery in 1974. In 1975, there were two breast biopsies. Her abdominal scars testify to an impressive surgical history.

Her husband indicates that she has been a drug abuser for at least ten years. He is unable to name all the drugs that she has overused but diazepam (Valium) and alcohol predominate. From time to time, she attended Alcoholics Anonymous. She has had group therapy at a mental health clinic plus some psychiatric care. She has been suicidal on several occasions. On one, she almost succeeded with an overdose and a tracheostomy was required. In the last two years she has been admitted at least ten times to hospitals in nearby cities. Her husband indicated that in 1975 and 1976 she was hospitalized at least seven times, and as many more in 1977. We have documentation of many other problems, including a cerebral concussion two years ago following a fall, ischemic heart disease with angina pectoris, several syncopal episodes diagnosed as conversion hysteria, and at least three admissions to alcohol detoxification wards of two nearby hospitals.

She visits physicians frequently seeking more and different medications. Five years ago, her husband wrote to 28 different physicians and requested that they give her no further medication. This helped for a while. She hides her doctor bills. Sometimes her husband does not learn that she has been to a new physician until he is billed for an overdue account.

DR. WEST: Anything special in her recent social history?

DR. TILTON: She lives at home with her third husband. He indicates that, primarily because of the constant illness, the ten years of their marriage have been somewhat unsatisfactory. He adds, however, that there was one excellent year; that year was good enough to make them all worthwhile. She has worked as a civil servant and a schoolteacher. She is now a homemaker.

DR. WEST: Thank you, Dr. Tilton. Is this indeed a typical case of Munchausen syndrome?

DR. JABBOUR S. SEMAAN *(Assistant Professor, Department of Health Sciences, School of Health)*: I understand that Munchausen syn-

drome involves persons who constantly consult physicians and go to hospitals to seek comfort. At the same time, they harbor resentment, rejection, and hostility toward their physicians. They are often well informed medically and try to manipulate their physicians. And they incessantly fabricate their symptoms.

DR. GEORGE ALLEN *(Instructor, Department of Community Health Services, School of Health)*: My understanding is that Munchausen syndrome involves habitual presentation for hospital treatment of an apparent case of acute illness with the patient giving a plausible and dramatic history, all of which is false. In this particular case, it does not all sound false. Some of it seems legitimate, so it does not precisely fit the pattern.

DR. RICHARD A. STEVENS *(Instructor, Department of Health Sciences, School of Health)*: How many of her surgical procedures had tissues diagnosed by pathologists?

DR. TILTON: We do not know. Of course, many of the reports are incomplete; many of the procedures do not generate specimens.

DR. WEST: Nevertheless, there is little doubt that this patient has had countless hospitalizations; far more than we have indicated. When I took her history I made a determined effort to do a particularly thorough job because I recognized a really unusual case. I spent 2½ hours with her. Later, I met her husband and learned that I had barely scratched the surface. There were hospitalizations by the score that she had not mentioned at all.

So we do have a case characterized by frequent presentation to hospitals and emergency rooms. That leads to another question: is Munchausen syndrome an attitude or is it a condition imposed on a person who is indeed constantly ill?

DR. SEMAAN: We do have a patient who has had considerable bad luck: years in concentration camps, beaten by guards, a platinum plate in her skull, genuine illness which drove her to alcoholism, two unsuccessful marriages, and so forth. In other words, she might well have a series of legitimate medical problems which life has imposed upon her. Perhaps this restates your question: is it really an attitude that we are talking about? Whether she exhibits that attitude or not is not the point. There are many ways of looking at a definition of a patient who pretends to be sick when actually he or she is not.

DR. WEST: Yes, but Munchausen syndrome has a connotation of something to be gained: time off from work, monetary compensation, more and stronger drugs, pity, adulation, love, or something else.

DR. SEMAAN: This woman does have a need. There are undoubted health problems associated with her complaints, so how can we clearly classify her case as Munchausen syndrome?

DR. WEST: Munchausen syndrome is defined in *Dorland's Medical Dictionary* as: "a condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false."[15] We readily admit that not all of her hospitalizations have been on false pretenses. Often, there has been something really wrong with her. Surely, a Munchausen patient is not immune from all illness. We know for sure that she has had multiple surgeries. But we do not know how many of these scores of visits to emergency rooms were medically necessary, how many were simply perceived by the patient as being necessary, and how many were purely factitious.

DR. SEMAAN: It appears from her history that almost every time she was admitted, there was a legitimate reason and an underlying pathology. Eventually they found her to be diabetic; it seems she had a legitimate reason for feeling weak and for fainting.

DR. WEST: But did she fail to take her proper diet and medication or was it all just a scheme to get herself hospitalized?

DR. ALLEN: It happened in a place where she could easily be seen and taken care of.

DR. STEVENS: Has she ever been confronted in an emergency room with a challenge that she might be mocking an illness?

DR. TILTON: To the best of my knowledge, whenever she presented herself in an emergency room, she was well prepared. It seems that there were always plausible symptoms, such as phlebitis-like leg pains or anterior chest pains.

DR. WEST: We do not have any idea how many times she may have been turned away from emergency rooms and not admitted to the hospitals. Let us come back to the question, is Munchausen syndrome a clear-cut clinical entity or is it something else—perhaps an attitude? Do you think there really is something that we can isolate and identify as Munchausen syndrome or are we talking about patients who are victims of circum-

stances resulting in many bouts of illness?

DR. TILTON: My feeling is that this case is a mixture and not a clear example of Munchausen syndrome. She has had some actual illness, but I think she has often overreacted and has manifested unduly the desire to be dependent on hospitals, drugs, and physicians.

DR. WEST: Does this symbolize a reversion to the womb?

DR. TILTON: Not necessarily, although in a hospital she indeed finds comfort, warmth, security, and attention. But it has to be much more complicated than that.

DR. ALLEN: More from her history: she was the daughter of a Belgian college professor and a Polish mother. They lived in a sociocultural atmosphere far above the norm. She was a sensitive girl, high-strung, and maybe on the borderline of psychosis. Her bitter experience during the war made it worse, so more problems surfaced and later in life she developed diabetes. The alcohol probably hastened that along. So she took the easy road. She did not try to overcome her problems. She learned that it could be a pleasant experience to be hospitalized. She was clever, a good actress, competent at fooling people, but not without some pathology.

DR. STEVENS: What about another possibility? Is she masochistic? Does she welcome pain? Does she like to go into a hospital to suffer the pain or just to receive attention?

DR. TILTON: I think she is masochistic to some extent. She loves to talk about all the invasive procedures she has undergone in intensive care units.

DR. ALLEN: Wouldn't we think more of the role of a masochistic person as someone who truly enjoys pain? I doubt if she does. I think she is using it as an excuse. A masochist enjoys being beaten up; a sadist enjoys administering the beating. I think this hardly applies to her, but she does enjoy the attention she gets from her symptoms.

DR. WEST: Dr. Tilton, is there any evidence that her husband might provide a sadistic component to this marriage?

DR. TILTON: Not at all. I do not think he has ever been physically abusive with her. She does feel that he has been insensitive to some of her ailments.

DR. WEST: He may have good reason.

DR. TILTON: They are not at all matched culturally. He is a laborer and has worked in a ceramics factory. His main interests are watching television and going to the movies. She yearns for a somewhat higher intellectual plane.

DR. SEMAAN: I want to comment again on this question of background. I am wondering if her behavior represents a yearning for attention. She came from a well-to-do European family, developed taste for the finer things, and got all the attention of society; in prewar Europe, the wealthy got lots of attention, the best seats in music halls, and so forth. Then along came the war and she was deprived—jailed, beaten, and abused in every way. Could not this be a cry for the past; a retrogression to a secure childhood in a prestigious home where bitterness, fear, and uncertainty just did not exist?

DR. WEST: You anticipate my next question which is on the same point: isn't the Munchausen syndrome a mechanism for sublimating a loss and sustaining one's ego? And do we physicians encourage this sort of thing? Are we responsible to some extent for the depth of her dependence on hospitals and emergency rooms?

DR. TILTON: Possibly, but right now she is somewhat better. The alleged abdominal mass proved nonexistent; she has reduced her weight by rigorous dieting. But this might only be a favorable phase she is going through. Sometimes I get the idea that she has a manic-depressive component along with everything else.

DR. STEVENS: You mentioned in the case history that she had at least one time attempted suicide. What were the circumstances?

DR. TILTON: As I recall, she was quite depressed at the time. Someone had given her pentobarbital and she overdosed on it.

DR. WEST: Was it more than just an attention getting gesture?

DR. TILTON: Yes, it was a genuine attempt. She had to have a tracheostomy. It was more than just a superficial slash of the wrist.

DR. WEST: Then what you are saying, Dr. Tilton, is that maybe this condition tends to have a cyclic component; perhaps as in bipolar manic-depression.

I would like for us to come to grips with an aspect of real significance to the family physician. Is this condition so rare that is matters little whether we identify it or not? Or is it perhaps much more common than we recognize, so we

should be alert to it? Once we do recognize it, is there an effective course of treatment? Could we forestall unnecessary expense? Maybe there are not that many patients with Munchausen syndrome; but through the years this patient has used extensive medical resources involving large expenditures of money. As family physicians, do we have an obligation in this regard?

DR. ALLEN: Of course we do. I also feel that if, in time, hospitalization is furnished free, Munchausen cases are likely to increase. Physicians should be alert to these problems just as they would be for cases of entrapment for addiction. When I practiced at a state psychiatric hospital we found many cases like this. People would feign illness just to get into the hospital, especially around Christmas.

DR. DAVID P. DUFFIE *(Psychiatrist, Assistant Professor, Department of Health Sciences, School of Health)*: This phenomenon can often be seen in mental hospitals, more when the weather is cold and food is scarce. At the other end of the spectrum is the kind of malingering shown by patients who induce factitious fever. Yet, their unconscious motivation is such that it is important for physicians not to hasten to diagnose malingering instead of hysteria, and for the same underlying reason that many good physicians are reluctant to use placebos. Because the moment they do, they have labeled the patient: "it's all in his head," when that is not the case. Studies have shown how the attitudes of providers subtly shift toward patients for whom they prescribe placebos. This is not therapeutic to the patient; neither is a hasty diagnosis of deliberate malingering.

DR. TILTON: It is most important that we consider cases like this. Most of us have seen them in varying degrees. These cases take so much of our time, effort, and money. As Dr. Allen brought out, if we get a nationalized health insurance program this phenomenon may well proliferate.

DR. WEST: And that is part of our issue here, is it not? Is there more of this which is not recognized? Should we have a reporting system, something akin to a tumor registry; a way of letting physicians know that this is happening—when, where, and by whom. This might have some real usefulness to the family physician.

DR. ALLEN: That's a good idea. You perhaps remember reading the famous case about the professional wrestler.[16] He did many things to get attention: presenting himself at an emergency room with swollen legs and a concealed hollow needle to suck blood. Then he would pretend to cough it up. He did this in a small town in Canada where they became suspicious. A nurse recognized him from a magazine article. The minute he was exposed, the man discharged himself. They telephoned every hospital in the surrounding area and alerted the staffs. One suggestion is that these people be catalogued. And at least one writer suggests fingerprinting of Munchausen patients.[17] We could also take their pictures and other information and circulate it widely among physicians and hospitals.

DR. WEST: And how about treatment, Dr. Duffie? Can these people be helped by psychiatric care?

DR. DUFFIE: The psychodynamics suggest that long-term psychotherapy would be a likely source of help. Unfortunately, patients such as these are often loath to submit to long-term therapy. On the other hand, prevention of costly hospitalization might well be in the sphere of the family physician. The family physician sees many patients with dependency problems who need much of his time which he just cannot give them. He sees them for five or ten minutes and writes a prescription; whereas, it would be different if he could take sufficient time, make a full report, and be adequately compensated. Of course, even by taking an hour to meet this woman's dependency needs, I think some of the unnecessary hospitalizations and trips to emergency rooms could have been forestalled. In total, the cost would be small.

DR. WEST: This points out a concern to all physicians. When the government sets up a program of compensation, they commonly do not consider prevention as being worth their consideration. Medicare and Medicaid permit precious little by way of preventive medicine. In a very real sense, these programs discourage prevention.

By way of summary, we may be wise to reread Asher.[2] His description of Munchausen syndrome is more cautious—perhaps more accurate—than the dictionary definition. He notes that the patient's story is largely (not entirely) composed of falsehoods, and wisely cautions that the patients "are often quite ill, although their illness is shrouded by duplicity and distortion." He delineates four key points in diagnosing the syn-

drome. You will note that he was incredibly precise in anticipating our own patient: (1) many surgical scars, often abdominal, (2) a truculent and evasive manner, (3) acute and harrowing but unconvincing symptoms, and (4) a pocket full of hospital records and doctor bills. Finally, Asher agrees that a mixture of personality problems is likely, with most cases having traits of hysteria, schizophrenia, masochism, or some other psychopathology.

In closing, let me suggest what might be called the "Munchausen dilemma": how to balance the patient's legitimate needs against a potential exploitation and misuse of the physician's time and the hospital's resources.

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