

Munchausen Syndrome by Proxy: A Clinical Vignette

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Munchausen syndrome by proxy is the act of one person fabricating or inducing an illness in another to meet his or her own emotional needs through the treatment process. The diagnosis is poorly understood and controversial. We report here the case of a 6-year-old boy who presented with possible pneumonia, nausea, vomiting, and diarrhea and whose mother was suspected of Munchausen syndrome by proxy.

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Munchausen syndrome by proxy, the act of one person fabricating or producing an illness in another in order to meet his or her own emotional needs via the treatment process, is a poorly understood and controversial diagnosis. While many refer to it as a psychiatric disorder, described by DSM-IV¹ provisional research criteria as an extreme manifestation of factitious disorder by proxy (Table 1),^{2,3} others argue strongly that it is more accurately described as medical abuse.^{4,5} Proponents of the psychodynamic perspective describe victims as the object used to regulate the perpetrator's "... intensely ambivalent but often destructive relationship with a physician."^{3(p110)} While acknowledging psychopathologic comorbidity, proponents of the medical abuse position state that perpetrators "... engage in the behavior willingly, not under the influence of some uncontrollable impulse and with full knowledge that it is wrong."^{5(p773)} We describe the case of a 6-year-old boy whose mother was suspected of Munchausen syndrome by proxy.

CASE PRESENTATION

A 6-year-old boy was seen in a physician's office for possible pneumonia. According to his mother, the child had been coughing and wheezing for the past 6 days. In

addition, the mother stated that the child had a temperature of 103.9°F (39.9°C), decreased oral intake for the last 3 days, and decreased urine output for 2 days. The child had been treated with home albuterol nebulizers and antibiotics for 3 days. Over the last 24 hours, the child developed nausea, vomiting, and diarrhea. A sibling in the house had been diagnosed with bronchitis.

The child's past medical history included neurofibromatosis, asthma, seizure disorder, attention-deficit/hyperactivity disorder, and pneumonia. The child had a prior workup that showed negative results for hyperglycemia. Current medications included methylphenidate, 20 mg twice per day; the albuterol nebulizer treatments; and amoxicillin, 250 mg 3 times per day. He had no known drug allergies.

Family history was positive for a mother with neurofibromatosis and insulin-dependent diabetes mellitus. There was also a family history of asthma. The child lived with his parents and 1 sister. There were no smokers in the household, but there was an inside dog. They had central heat, and the boy's immunizations were current.

Physical examination revealed a well-nourished, well-developed, lethargic, and ill-appearing boy who was uncooperative and somnolent during the initial examination. His temperature was 96.5°F (35.8°C), pulse rate was 129 beats per minute, blood pressure was 116/56 mm Hg, and respiratory rate was 28. His eyes had a disconjugate gaze, but the remainder of the HEENT examination was normal. Results of cardiovascular examination were normal, and his lungs were clear to auscultation with no wheezing noted. Although the neurologic examination was difficult to assess secondary to the child's lethargy, he did move all extremities. His skin showed multiple café-au-lait areas and was extremely diaphoretic.

Initial laboratory evaluation revealed a white blood cell count of 16,200/mL (normal range, 3500-10,000/mL), plasma sodium level of 140 mmol/L (normal range, 135-145 mmol/L), plasma chloride level of 106 mmol/L (normal range, 98-107 mmol/L), plasma potassium level of 2.3 mmol/L (normal range, 3.5-5.0 mmol/L), plasma carbon dioxide level of 20 mmol/L (normal range, 22-28 mmol/L), normal serum urea nitrogen and creatinine levels, and a plasma glucose level of 31 mg/dL (normal range, 60-110 mg/dL). Owing to mental status concerns,

a computed tomography scan of the head was performed with normal results. The child was admitted for further evaluation.

Following multiple injections of intravenous (i.v.) glucose during the first 3 hours after admission, the child's blood sugar rose appropriately, only to fall again shortly after the physician left the room. The patient's blood sugar level then normalized for the next 48 hours. On day 3, the child's mother was informed that administration of i.v. glucose was being discontinued. That night, the child's blood sugar level dropped into the high 40s despite repeated attempts to treat with i.v. solutions. Curiously, once the day shift started, the child's blood sugar level again normalized.

Very early the next morning, the child's blood sugar level once again dropped, this time into the 30s, with poor response to appropriate measures. Growth hormone, cortisol, insulin, C peptide, and lactate levels were measured. The child's blood sugar level continued to fluctuate despite aggressive management. Of interest is that at one time during this episode, the i.v. tubing was noted to be leaking. Upon inspection, the tubing had a hole that looked like it was created by a needle.

Once the blood sugar level normalized again, dextrose was removed from the i.v. solution. Without the mother's knowledge, however, the i.v. bag was intentionally mislabeled to suggest ongoing dextrose administration. The child's subsequent blood sugar levels remained normal.

Suspicions that the mother was injecting some of her insulin into the child's i.v. access were triggered by the fact that her son's abnormally low blood sugar levels occurred only when she was in the room. The mother also voiced concern that her child was becoming a diabetic just like her, and the child knew how to perform his own finger prick for glucose monitoring. Behavioral aberrations on the part of the mother were also noted, as evidenced by her remaining curled up in a fetal position on the parent's bed during her child's most severe hypoglycemic episode.

On the fifth day of admission, the mother was removed from the room and the child's blood sugar level subsequently remained normal. Laboratory results received that day from analysis of blood drawn on day 3 showed an insulin level of 9776 $\mu\text{U}/\text{mL}$ (normal range, 5–25 $\mu\text{U}/\text{mL}$) and a C peptide level of 0.5 ng/mL (normal range, 0.8–4.0 ng/mL). The mother subsequently expressed concern about her child's blood sugar level and confessed to covert administration of insulin. The child was removed from the mother's custody and made a full recovery.

DISCUSSION

Although Munchausen syndrome by proxy has alternately been described as "a rare psychiatric disorder"² and "more common than previously believed,"³ it is clearly a

Table 1. DSM-IV Research Criteria for Factitious Disorder by Proxy^a

- A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
- B. The motivation for the perpetrator's behavior is to assume the sick role by proxy.
- C. External incentives for the behavior (such as economic gain) are absent.
- D. The behavior is not better accounted for by another mental disorder.

^aAdapted with permission from the American Psychiatric Association.¹

serious and potentially life-threatening situation for the victim, with a mortality rate approaching 10%.⁶ Treatment success rates for perpetrators are notoriously poor.^{3,5}

Perpetrators of Munchausen syndrome by proxy are typically mothers, and the victims are usually their young children, although fathers have been identified as perpetrators, and elderly individuals have been victims. The most common illness presentations are seizures, failure to thrive, vomiting and diarrhea, asthma and allergic reactions, and infections.⁶ These initial assaults are typically compounded by subsequent painful medical procedures performed in an effort to diagnose and treat what appears to be a most perplexing and elusive medical condition.

Typical warning signs of Munchausen syndrome by proxy include^{7,8}

1. Persistent or recurrent illness that cannot be explained
2. Discrepancies between clinical findings and history
3. Symptoms that occur only when the mother (or suspected perpetrator) is present
4. Symptoms or treatment course that is not clinically consistent
5. A working diagnosis that is less plausible than Munchausen syndrome by proxy
6. A mother who welcomes even painful medical tests for her child, is constantly at the bedside, and has previous medical experience, yet seems less concerned than the medical staff about the health of her child
7. Family history of sudden or unexplained infant death

It is important, however, to differentiate Munchausen syndrome by proxy from similar concerns. Munchausen is not to be confused with⁹

1. Anxiety resulting in excessive but nonabusive care for a child
2. Noncompliance resulting in a child's persisting or worsening illness
3. Malingering with the goal of some external gain (e.g., financial benefits)

In attempting to diagnose Munchausen syndrome by proxy, it is helpful to separate the mother (or suspected perpetrator) from the child (or other victim) and evaluate for symptom continuation. This separation may also prove to be an important first step in protecting the victim from further injury, which is of primary importance. While referral to additional treatment specialists may be of value, overall review of the case history by a physician unfamiliar with the patient may help clarify concerns regarding possible abuse. Medical professionals, trained to provide supportive care for patients and their families, are particularly vulnerable to deceitful parents who give the appearance of being exemplary caregivers.

Evaluation of previous medical records for the patient and any siblings may suggest illness patterns. A detailed social history can be helpful in identifying dysfunctional family dynamics, and involvement of a multidisciplinary treatment team can be instrumental in further assessing the situation and initiating any necessary legal action. As always, it is important to carefully and objectively document all findings in the medical record.

Drug names: albuterol (Proventil and others), amoxicillin (Amoxil and others), methylphenidate (Ritalin and others).

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