A CASE OF MUNCHAUSEN SYNDROME BY PROXY: IS IT A MISDIAGNOSIS?

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ABSTRACT

Introduction

Child abuse is an area in Forensic Medicine where the diagnosis and management could be difficult. A deep history and close inward observation is a must where there is the slightest doubt of child abuse, in order to identify compounding factors and address accordingly. Here we report a case of repeated episodes of hematuria which was extensively investigated in three tertiary care hospitals revealing no cause, ultimately the mother being discovered as the culprit.

Case report

A three year old boy who was extensively investigated for repeated episodes of gross hematuria since the age of seven months was admitted to Teaching Hospital, Peradeniya with another episode of gross hematuria. The child was clinically normal and investigations including blood, imaging studies and renal biopsy were unremarkable. Urine checked for bar bodies was positive. A case conference was held and it was decided to keep the child under parental custody under supervision of medico-legal authorities, while the mother is followed up at the psychiatry clinic for depression.

Discussion

Munchausen syndrome (MS) by proxy is a psychiatric disorder which consists of fabricating or inducing illness in a child, usually by his mother, leading to unnecessary and potentially harmful medical investigations and/or treatment which are seen in this case as well. Thus this emphasizes the importance of thinking of MS, before going into potentially harmful investigations when the basic investigations are normal and identifying the importance of having an interlinked e database system in medical facilities in countries like Sri Lanka.

INTRODUCTION

Munchausen syndrome by proxy (MSBP) which is also known as pediatric condition falsification[1] or fabricated or induced illness[2]**,** is an unusual form of child abuse, subjecting the child repeatedly to multiple medical procedures, both diagnostic and therapeutic which might lead to significant morbidity and pose threats to the life of the child. Compared with other forms of child abuse, MSBP has proven to be a child maltreatment associated with rather different diagnostic and legal problems.

Seeking treatment from different doctors at different places in order to conceal the truth, imposes difficulties in diagnosis. If an interlinked data system for each patient between hospitals were to exist, the issue of misdiagnosis and unnecessary repeated investigations would easily be overcome.

CASE REPORT

A three year old boy who has had repeated episodes of gross hematuria since the age of seven months, was admitted to a tertiary care hospital in the central province, with an episode of gross hematuria. He had been extensively investigated in three tertiary care hospitals previously due to changes in residence.

The child was a product of a non-consanguineous marriage and was the second-born of a family of three children. The antenatal history was unremarkable while the birth weight was 1.9 kg. The child was given PBU (Premature Baby Unit) care for the first two days for hypoglycemia.

The child was first brought to a tertiary care hospital at the age of seven months with a two months' history of on-and-off gross hematuria with straining during micturition. The child did not have features of an infection and was clinically normal with normal blood pressure and no abdominal masses detected on examination. All the blood investigations were normal while the urine full report (UFR) showed red blood cells (field full) without any evidence of infection. Ultra Sound Scan reports and X-rays were normal.

The child was presented with the same clinical picture at the age of 2 years and one month to the same hospital. During this admission, too, all the investigations except the UFR were normal. The child had to undergo a renal biopsy which revealed no abnormality.

The child presented with a similar history, 3 months later and again all the blood investigations and X-rays were normal. This time he had to undergo a cystoscopy under general anesthesia, which was found to be normal.

During the most recent admission (at the age of three years) the child presented with a similar history. The mother had complained of a similar hematuric episode in her other child who was one year younger, which was investigated, but the medical records were not available for our perusal. The child had to undergo several blood, urinary and radiological investigations during this hospital stay as well, all being unremarkable except for the hematuria in UFR. Urine which was collected under supervision showed no gross hematuria, while the urine which was collected by the mother was red in color. On suspicion of Munchausen Syndrome by Proxy, the urine which was collected by the mother was checked for bar bodies and it was positive in this male child.

Clinical forensic evaluation excluded any form of physical or sexual child abuse. On further inquiry it was revealed that the mother, who is a nursing officer in Jaffna, has under gone severe mental stress in the past. She has undergone a left-sided mastectomy for carcinoma breast few years back, she has lost a child during the time of war and her husband has been in custody for 2 years recently. Her past medical history was unremarkable. She appeared irritable and showed lack of warmth and attachment towards the child. She was diagnosed as having depression on referral to the Psychiatrist.

A case conference was held and this was diagnosed as a case of MSBP. It was decided to keep the child under parental custody under supervision of medico-legal authorities, while the mother is being followed up at the psychiatry clinic.

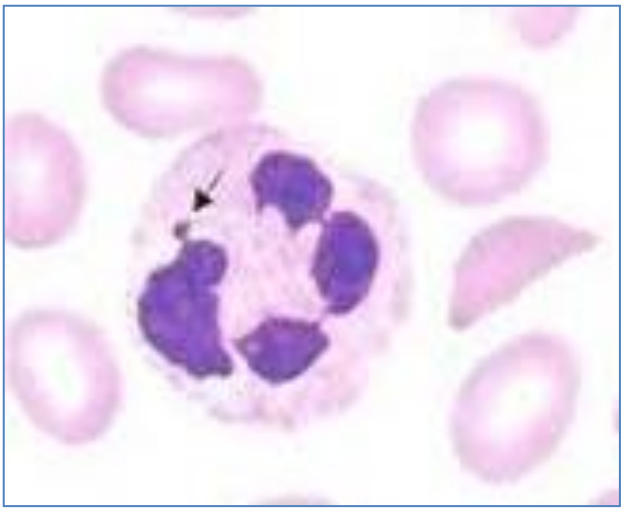

Figure 1: Barr body is indicated by the arrow

DISCUSSION

Child abuse is an area in Forensic Medicine where the diagnosis and management could be difficult. MSBP is a psychiatric disorder where there is fabrication or induction of illness in a child, usually by his mother[3,4], very rarely by the father[5]. This poses even more diagnostic problems as the caretakers' actions to fabricate the illness usually evade early detection, as the symptoms and signs they report seem plausible. Furthermore they appear concerned about the child and they might even have had a training in nursing or medical/paramedical training[3]. This leads to unnecessary and potentially harmful medical investigations and/or treatment and may pose severe morbidity and mortality to the child's life, as seen in this case. Thus, medical professionals continue to struggle with this form of child abuse.

Boys and girls are victimized almost equally[6]. Although several children within a family may be victimized sequentially, it is unusual for more than one child to be victimized within any given period of time[7]. In this case too, the younger sibling had similar symptoms which may have been the result of MSBP, but the medical records were not available for confirmation. Most of the victims are infants and toddlers, presumably due to the fact that younger children lack the verbal skills necessary to disclose their abuse and are relatively helpless physically[3,6,8,9,10]. Although victimization of the children commonly begins early in life, there is usually a delay in making the correct diagnosis. In two series, average time from onset of symptoms and signs to diagnosis was 15-22 months[4,6], it might be as long as 20 years[6] or never[11].

The commonest presentation of MSBP reported in literature includes any form of bleeding, seizures, central nervous system depression, apnea, diarrhea, vomiting, fever and rash[12,13]. According to Feldman etal., 25% of the children with MSBP had renal or urologic issues. The falsifications done by the caregivers included false or exaggerated history, specimen contamination, and induced illness. In our case the mother had contaminated the child's urine sample with her blood without being noticed by medical professionals. Caretakers also intentionally withhold appropriately prescribed treatment[14,15]. They usually welcome painful and invasive tests in the child and grow anxious if the child improves[16].

Usually there is a history of family dysfunction, with the father being uninvolved and emotionally distant and the mother having few social outlets[17]. The motive for the perpetrators' behavior is receiving satisfaction and attention from the investigations and treatment that the child receives from the medical environment as part of a unique mental disturbance. In this case the severe mental stress the mother was subjected to in the past, may have attributed to her current psychiatric condition.

Some evidence suggests that these victimized children may go onto develop Munchausen syndrome themselves[18] or some type of personality disorder later in life if they survive.[19,20] According to Fissure etal., features of MSBP may be seen in one-

third of patients, and the rest may have depression or personality disorder[21].

Because MSBP is a relatively uncommon form of maltreatment, pediatricians need to have a high index of suspicion when faced with a persistent or recurrent illness or an unusual symptom or sign that cannot be explained and that results in multiple medical procedures, or when there are discrepancies between the history, physical examination, and health of a child[22,23.] Insistence by a parent that more investigations should be carried out, including invasive ones, would be a warning sign that MSBP might be present. The primary care provider may be in a position to raise the question of MSBP because he/she may be able to recognize larger dynamics at play between child and family that are less apparent to subspecialists because he/she has an existing overtime relationship with the family[24].It also stresses the importance of having an interlinked e-database system in medical facilities in countries like Sri Lanka, in order to manage the same case if presented to different hospitals, as a collective effort with inputs from the medical officers who handled the case previously.

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