

# Munchausen's syndrome: a near-fatal case

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## Introduction

Presentation of a factitious disorder can be convincing and dangerously misleading, resulting in inappropriate clinical management and possible death. A 27-year-old woman presented with a medical history of malignancy and type 1 diabetes. She requested that no resuscitation be offered and convinced the admitting team to initiate 'end of life' care. Impressive use of medical jargon and familiarity with the clinical presentation of ovarian cancer made her more plausible. The small quantity of intravenous insulin required to maintain euglycaemia alerted suspicions and led to the diagnosis of Munchausen's syndrome.

**Key words:** Munchausen's, factitious disorder, DNAR, type 1 diabetes, ketones

## Case report

In factitious illnesses, the patient consciously and voluntarily produces physical symptoms of illness. The term Munchausen's syndrome is reserved for individuals with particularly dramatic, chronic or severe factitious illness.<sup>1</sup> This report aims at drawing clinician attention to the presentation of factitious disorders. A high index of clinical suspicion is required to avoid unnecessary treatment and harm to the patient.

## Presentation

During a weekend a 27-year-old German woman was brought in by the ambulance crew to the emergency department with complaints of abdominal pain, vomiting and elevated blood glucose with positive urine ketones. The history was from the patient as she had no hospital or GP records and did not have an NHS number. She informed staff that she had been diagnosed with advanced ovarian cancer a year ago, treated with subtotal colectomy and temporary ileostomy, followed by chemotherapy and radiotherapy. The oncologists had decided on palliation after a course of failed trial drug treatment in London. The latest scans undertaken a week before in Germany revealed pulmonary and cerebral metastases.

She also suffered from type 1 diabetes for which she was on

a basal bolus insulin regimen requiring around 60 units of insulin daily.

Her history was further complicated by the presence of factor V Leiden mutation and seven miscarriages, the last one associated with a deep vein thrombosis and pulmonary embolism. She also gave a history of seizures 3 months previously for which she had been admitted and treated with phenytoin. She was a barrister by profession and was currently representing a client in Cambridge.

## Initial management

She called the ambulance when she reported that her capillary glucose was more than 25 mmol, with positive urinary ketones. She had administered a dose of subcutaneous insulin before calling the paramedics and on arrival in the admission unit her blood glucose was back in the normal range. Clinical examination was unremarkable, except for multiple surgical incision scars over the anterior abdomen. As she had abdominal pain complicated by retching and vomiting, she was prescribed antiemetics, analgesics and intravenous fluids. A central venous line was inserted as her peripheral veins were difficult to cannulate. Intravenous insulin infusion was commenced due to persistent vomiting.

She was reviewed by the on-call consultant. She stated that, because a recent brain scan confirmed metastatic deposits from the tumour, she would prefer 'end of life' care with no attempt at resuscitation. A 'Do Not Resuscitate' form was signed by the consultant. She declined imaging on the grounds that she was on a palliative care pathway.

## Clinical progress

The events which followed admission included a telephone call from Germany informing our patient that her father had passed away due to a ruptured aortic aneurysm. She said that her family was now on the way to Germany for her father's funeral and not contactable. She subsequently had a fitting episode in the ward that was treated with intravenous diazepam and had persistent severe abdominal pain requiring frequent doses of liquid oral morphine. She also requested antiemetic injections and required nasogastric tube insertion for nausea and vomiting.

During management over the weekend, clinicians noted her negligible requirement of insulin on the variable rate intravenous insulin infusion. She appeared indifferent to the complexity of her illness and had excellent command of complex medical terminology.

## Clinical exposure

After persuasion she agreed to have a chest X-ray, which showed no evidence of pulmonary metastases. Variable rate insulin

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**Table 1** Diagnostic features of Munchausen's syndrome

Essential features	Supporting features
<ul style="list-style-type: none"> <li>• Pathological lying (pseudologia fantastica)</li> <li>• Peregrination (travelling or wandering)</li> <li>• Recurrent feigned or simulated illness</li> </ul>	<ul style="list-style-type: none"> <li>• Borderline and antisocial traits</li> <li>• Deprivation in childhood</li> <li>• Equanimity of diagnostic procedures</li> <li>• Equanimity for treatments or operations</li> <li>• Evidence of self-induced physical signs</li> <li>• Knowledge/experience in the medical field</li> <li>• Most likely to be a male</li> <li>• Multiple hospitalisations</li> <li>• Multiple scars (usually abdominal)</li> <li>• Police records</li> <li>• Unusual or dramatic presentations</li> </ul>

infusion was stopped and she remained normoglycaemic 4 h later. All 'end of life' medications were stopped and a psychiatric consultant review was sought.<sup>2</sup> The psychiatrist diagnosed poly-symptomatic Munchausen's syndrome, meeting several of the clinical requirements<sup>3</sup> necessary for this diagnosis (see Table 1).<sup>4</sup> Her physical complaints were plausible and stated articulately, with medical sophistication.

## Discussion

In 1951, Asher described a psychosomatic disorder he termed Munchausen's syndrome.<sup>5</sup> Patients with this syndrome repeatedly seek admission into medical facilities with apparent physical or mental distress, offering plausible stories supporting the nature of their disorder. Once admitted they may submit themselves to radical medical treatment and then discharge themselves against medical advice.<sup>6</sup> There are no reliable statistics regarding the number of people in the UK who suffer from this disorder, but it is considered to be rare. In hospital populations it is estimated that 1% will meet the criteria.

Our patient presented with a plausible history of terminal illness due to metastatic ovarian carcinoma. She underwent invasive procedures including central venous cannulation and nasogastric tube insertion. She had many medications, both oral and intravenous, and she requested subcutaneous insulin. Minimal intravenous insulin requirement alerted suspicion to possible Munchausen's syndrome. Once clinicians were able to confirm that some aspects of her story were false, the patient took her own discharge.

The unusual aspect of this case of Munchausen's syndrome was the request of the patient, shortly after admission, not to be resuscitated due to alleged progression of her metastatic ovarian cancer. This was plausible due to her impressive medical knowledge and her recent abdominal and pelvic scars. By persuading the admitting consultant to fill out a DNAR form, no imaging was arranged and 'end of life' medications were commenced. These medications could have resulted in the patient's death.

In addition, she had pseudo-seizures and was being considered for intravenous anticonvulsant therapy and was already receiving intravenous dexamethasone for her cerebral metastases. Furthermore, she requested boluses of subcutaneous long-acting insulin, which could have resulted in neuroglycopenia. If



## Key messages

- Diagnosis of Munchausen's syndrome can be difficult when the symptoms are stated articulately with medical sophistication
- Missing a diagnosis of severe factitious disorder can lead to inappropriate management and potential death
- DNAR and End of life decisions have to be carefully decided even if there is a slightest index of suspicion

this had developed, it could have caused genuine seizures and coma. In view of her DNAR, this may well have been managed conservatively until she passed away.

Should her Munchausen's syndrome have been diagnosed earlier during the course of admission? She was admitted on a busy weekend take with abdominal pain, nausea and vomiting. In view of her alleged type 1 diabetes she received appropriate treatment with intravenous fluids, intravenous insulin and antiemetics and, in view of her abdominal pain, she required analgesia. Her admission glucose was normal, but she claimed to have taken a dose of subcutaneous insulin just before the paramedics arrived. She knew the names and dosages of her complex basal bolus insulin regimen. She also explained in detail the diagnosis, investigations and management of her alleged metastatic ovarian cancer. She claimed to have arrived recently in the country from Germany and that her medical documentation was in her hotel room (but there were no relatives available to bring it). Given the depth of her medical knowledge and her presentation with clinical symptoms (albeit self-induced), earlier detection of Munchausen's syndrome would have been difficult.

Thinking laterally, type 1 diabetes – being one of her alleged diseases – paved the way to clinical suspicion and diagnosis of the condition. The case may have been even harder to diagnose if diabetes was not reported as part of the factitious illness or the discrepancy of history and dose of insulin requirement had gone unnoticed. The case also highlights the potential hazards of DNAR policies in patients with Munchausen's syndrome.

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