Changing focus of symptoms: A rare case report of Munchhausen's syndrome

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Abstract

Factitious disorder, commonly called Munchhausen's syndrome, is a rare disorder that lacks evidence-based guidelines. Reporting clinical cases is important for sharing clinical experiences and treatment strategies. The symptoms and progression of the following case have not been previously reported in the literature. Here, we report a case involving a 41-year-old Caucasian with a suspected psychosomatic disorder. After intensive multi-professional diagnostics, we concluded that the patient had factitious disorder. The symptoms in this case changed rapidly during treatment, which posed a challenge. For factitious disorder, establishing interdisciplinary exchange is important. Symptoms that are normally treated by internists are most commonly described in the literature. This case demonstrates that psychiatrists are challenged by this diagnosis and should consider the possibility of factitious disorder when seeing patients diagnosed with somatoform disorders. The most important clinical conclusion was the importance of involving the patients' relatives in the treatment of patients with factitious disorder.

Introduction

Munchausen's syndrome is a very rare disease first described in 1951 by Richard Asher, who named the disorder after Baron Munchausen, a man famous for his wild fabricated tales of travels.[1] Today, Munchausen's syndrome is also called factitious disorder. The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) distinguishes between symptoms that are self-inflicted by the patient and symptoms that the patient imposes onto other people.[2] Patients with factitious disorder repeatedly present with symptoms. They consult several specialists, which leads to extreme hospital hopping.[3] Both symptoms and personal data can vary slightly from visit to visit.[4] The patients' reasons for repeated visits are often known to themselves but not to other people and may include attention from other people and a secondary morbid gain. Factitious disorder is challenging for clinicians to diagnose.[3]

The following case shows a patient who exhibited a change in his somatic symptoms, which were present for years, to psychiatric symptoms after he was diagnosed with Munchausen's syndrome.

Case Report

We present a case of a 41-year-old male Caucasian opera singer. He presented at our psychiatric emergency ambulance after consulting the internal medicine department with various symptoms, such as dizziness, diffuse abdominal pains and incontinence. Psychiatric complaints, including a bad mood and lack of motivation, were also reported in his psychopathological findings. Some days before, the patient consulted two other hospitals due to gastrointestinal symptoms. Neither the colleagues at these hospitals nor the local internal medicine clinician could find any somatic causes for the patient's symptoms. He was referred to our ward for diagnostic classification. Initially, the patient focused on his somatic symptoms, and lab testing showed an isolated high lactate dehydrogenase value that led to broad diagnostic investigations. We referred the patient to several interdisciplinary departments (Table 1). After approximately six weeks of somatic work-up, the patient presented with an anal fissure that was most likely induced by manipulation.

After considering all diagnostic results and the patient's behavior, we suspected factitious disorder. A personality disorder interview (SCID II),[5] was performed and showed a narcissistic/borderline/paranoid-accentuated personality. Furthermore, the patient often reported different facts regarding his childhood and social life. The patient agreed to obtain all reports from all the other clinics he consulted in the past seven years, none of which had ever found a somatic cause for his symptoms. The reports from psychotherapy sessions and multiple professional conversations always stated that the patient suffered mental and physical abuse in his early childhood and could not cope with his mother's death. Based on the extensive somatic and instrument-assisted internal diagnostics that yielded no pathological findings, the patient's behavior on the ward and his accentuated personality, we specified the diagnosis as a factitious disorder. The patient fulfilled all the criteria of the DSM-5 classification of factitious disorder combined with multiple personality disorder; the diagnosis was based on a diagnostic interview and verified with psychological testing. We confronted the patient with our suspicion and explained the reasons we had diagnosed this rare and difficult-to-diagnose disorder. The patient accepted our diagnosis and recognized himself in the DSM criteria. For several days after the given diagnosis, he seemed relieved and motivated to continue psychotherapy. After an initial improvement in his symptoms and a positive response, the patient started to present more psychiatric symptoms. One day, he was found in a very tense, almost dissociative condition. He described himself as a puma, bared his teeth and made a

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deep roaring sound. For several hours, he could not come out of this state; even a strong ammonia smell did not help, and he started biting himself. In the following days, he continued to experience dissociative states. He hurt himself and began to exhibit obsessive-compulsive symptoms. The only medication that was partially successful in improving those states was lorazepam (in doses up to 7 mg/24 h). An off-label therapy regimen of atypical neuroleptics (quetiapine >1000 mg/24 h; olanzapine >15 mg/24 h) did not improve the dissociative symptoms or the compulsive and aggressive symptoms. However, every time we tried to explore the patient's psychiatric symptoms, he showed no insight or real suffering, and after a while, the symptoms switched from the initial dissociative and compulsive/aggressive state to a depressive and agitated mood with feelings of insufficiency and situation-based anxiety attacks. To help the patient reintegrate into social and working life, we organized a meeting with his siblings, who were reported to be the most important relatives in the patient's life. We obtained some detailed information beforehand, such as anamnestic reports that included differing descriptions of the patient's childhood. The patient was described as a *good actor* and a *notorious liar*. The previously missing information regarding the patient's childhood and childhood experiences was obtained via four family meetings and through structured relative interviews lasting 45 min that were conducted by one psychiatric specialist and two psychologists). Additionally, a systemic psychological interview strategy involving circular interviews with the siblings was used to collect the relevant anamnestic information.

The relatives told us that we were the first department that had involved them and that they had wanted to be involved for a long time. They felt relieved and motivated to keep caring for their brother.

Discussion

We report this case to call attention to a disease that is still rare and difficult to diagnose and treat.

Even in a specialized psychiatric ward, identification of the correct diagnosis took time. The main findings, such as childhood abuse, loss of the beloved mother, hospital hopping and a very distinct narcissistic personality were the major criteria. Furthermore, the variations in the reported personal background and symptoms fit the *pseudologia-phantastica* phenomenon described by the DSM-5.[2] Factitious disorder is classified as a sub-category of complex somatic symptom disorders in the DSM-V. Patients must fulfill the criteria in three clusters (A-C): A (somatic symptoms-one or more somatic symptoms that are distressing and/or result in significant disruption in daily life), B (excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns), and C (chronicity: although any one symptom may not be continuously present, the state of being symptomatic is chronic for at least 6 months). We spent a substantial amount of time with this patient to verify the diagnosis and identify a treatment strategy. After diagnosing the patient with Munchhausen's syndrome, we found it difficult to accept the subsequent deterioration in his condition and when change in symptoms. We wondered whether this change was our fault; we also questioned whether confronting the patient with his diagnosis was a mistake.[6] On the one hand, we knew that patients with factitious disorders often do not accept the diagnosis, and such denial was demonstrated by our patient. On the other hand, we faced an ethical dilemma. We sometimes found one another in a disappointed, almost desperate state because we did not know the best course of action due to an absence of evidence-based guidelines or registries for factitious disorders.[7] Additionally, the patient's medication was difficult to adjust because of the lack of guidelines. We attempted to modify the patient's depressive mood with venlafaxine (>225 mg/24 h) and imipramine (150 mg/24 h). During his dissociative state, we tried to calm him down with a low dosage of lorazepam, which worked for a while. However, we had no information about the medications' side effects or interactions with the disease. Since benzodiazepines can lead to paradoxical reactions, they might not be an appropriate therapy for patients with factitious disorders.[8] Therapy for these patients should focus on psychotherapy and determining the motivation for the patient's behavior. The patient consulted internal and psychiatric departments for seven years and incurred tremendous treatment costs. This type of patient is a substantial burden on the health insurance system.

Conclusions

The most important conclusion of this case might be that any existing relatives and close friends must be involved in the patient's therapy as soon as possible (systemic-based approaches seem to be the most successful strategy for such patients).

The relatives of our patient confirmed the diagnosis and were relieved and grateful after we talked to them. In our case, the relatives represented the only source of stability in the patient's life. Because psychiatric diseases are treated systematically and multidimensionally,[9] we are convinced that the relatives of patients with factitious disorders should be integrated into treatment. Given the ignorance of the patient's diagnosis, the integration of relatives can save time and costs. Additionally, factitious disorders seem to be a major challenge and a great strain on relatives, and not only the patient suffers from this disease. For factitious disorders, a multidimensional treatment regimen should include the integration of relatives, and research and systematic diagnostic guidelines are urgently needed.

Table 1. Clinical diagnostics.

Diagnostic	Result
Electroencephalogram	No pathological finding
Rectoscopy	No pathological finding
Consultation proctology	No pathological finding
Thorax X-ray	No pathological finding
Cranium computed tomography	No pathological finding
Thorax/Abdominal computed tomography	No pathological finding
Cervical magnetic resonance-angiography	No pathological finding
Liver magnetic resonance imaging	No pathological finding
Consultation hematology	No pathological finding
Tilt table test	No pathological finding
External cranial ultrasound	No pathological finding
External cranial duplex	No pathological finding
Consultation neurology	No pathological finding
Transcranial ultrasound	No pathological finding
Consultation psychosomatic department	Focus on psychiatric symptoms
SCID-II Testing	Narcissistic, borderline paranoid, accentuated personality

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