ABSTRACT

Munchausen syndrome by proxy (MSBP) is emerging as a serious form of child abuse. It is an intentional production of illness in another, usually children by mothers, to assume sick role by proxy. It is poorly understood and a controversial diagnosis. Treatment is very difficult. We present a case of 9-year-old boy brought to Pt. B. D. Sharma, PGIMS, Rohtak, a tertiary care hospital in northern India by his father and paternal uncle with complaints of hematemesis since July 2012. He underwent many invasive procedures until the diagnosis of MSBP was finally considered. The examination of the blood sample confirmed the diagnosis. The child was placed under custody of his mother. The case was reported to social services, which incorporated whole family in the management.

Key words: Child abuse, Munchausen syndrome, proxy

INTRODUCTION

Munchausen syndrome by proxy is an intentional production of illness in another to assume sick role by proxy with absent external incentives for the behavior. The perpetrators are commonly the Mothers, but father perpetrators have also been reported. The victims are usually under 6 years of age. These cases more often remain undiagnosed resulting in frequent unnecessary investigations and hospitalizations leading to considerable morbidity and even mortality. There is a tendency to participate in the deception and to believe that they are disabled in those children who survive and grow older. Treatment is difficult, and early recognition can prevent possible hazards to the patient and waste of medical resources. We report a case of 9-year-old boy with unusual presentation of MSBP.

CASE REPORT

A 9-year-old boy accompanied by his father and paternal uncle presented to pediatrics outpatient department of Pt. B. D. Sharma PGIMS Rohtak with complaints of fit-like episodes for last 3 years and hematemesis for 1 year. The general physical examination of the child was absolutely normal. Routine investigations complete hemogram, bleeding and clotting time, prothrombin time, partial thromboplastin time, INR were done and found to be within normal range. Earlier treatment records showed that the child was already taking anti-epileptic treatment, but still there were fit-like episodes. The child was admitted in pediatrics ward. Upper GI endoscopy, fiberoptic laryngoscopy, and bronchoscopy revealed no abnormality. CT scan head and EEG brain were also normal. The previous records showed multiple admissions of the child.
in the past for similar complaints. The child had undergone many invasive investigations earlier from different hospitals. Father and paternal uncle used to stay with the child and showed over concern about the child’s illness and repeatedly requested for more investigations. The child had 2-3 fit-like episodes in the ward in front of treating team, which were not true seizures. The child also had repeated episodes of hematemesis in the ward, and each time, father collected the sample in the bottle to show to the treating doctors. The sample collected did not clot for 2-3 days, which aroused suspicion, and was sent for microscopic examination. It was found that there were no RBCs in the sample. The sample contained only salivary secretions mixed with some reddish-brown chemical.

The child was referred to psychiatry department and admitted there. The child was separated from father and paternal uncle, and mother was asked to stay with the child. There was no hematemesis in next 1 week. The child remained comfortable with his mother, and during repeated interviews, child reported to the treating team that his father and paternal uncle used to give him betadine solution just before the act of emesis. The father and paternal uncle were confronted, but they were reluctant to agree their role in deception. They displayed anger and disbelief and insisted that their son should be immediately discharged and refused to contact the social services. Mother and child were incorporated in the treatment part. The social services decided to put the child under mother’s custody.

Mother informed that the reason for this fabrication may be her dysfunctional family life. Father and paternal uncle were unemployed and used to stay idle at home. On multiple times, they were asked to do some work for earning, but they never tried. She used to do work in the field as well as at home. There were frequent fights with them due to poor financial condition at home.

**DISCUSSION**

Meadow described Munchausen syndrome by proxy for the first time.\(^5\) Since then, many cases have been reported in the literature.\(^6-8\) Our patient was brought with one of the most common presentations of MBSP, i.e., gastrointestinal bleeding (hematemesis). This symptom is easy to fabricate and justifies the father taking the child to hospital multiple times. It forces the attending physicians to order invasive investigations indirectly contributing to the damage inflicted. There are some specific features, which lead to correct diagnosis in present case. The illness was prolonged, unexplained, and repetitive. The observations and investigations were inconsistent with reports of father and paternal uncle and condition of the child. According to them, the child was bleeding so frequently, despite, there was no history of blood transfusion. Also, the signs and symptoms occur only in the presence of the father and paternal uncle and were conspicuously absent when child was separated from them. Our patient’s caretakers were very eager to stay in the hospital and accepted repetitive all invasive procedures without any sign of worry.

It is suggested to examine the blood in the specimen if the symptom is bleeding of any origin.\(^9\) In our patient, examination of blood and separation of caretakers from the child confirmed the diagnosis.

There are few unusual presentations observed in our case, which are rarely reported in the literature earlier. Firstly, the perpetrators were the father and paternal uncle instead of the mother. Relative being the perpetrators was observed for the first time. Secondly, the caretakers were giving betadine gargles to the child just before the act of emesis and not using any blood sample. Thirdly, our patient also had pseudo seizures since 6 years of age due to ongoing psychosocial stressors. He accepted his illness being fabricated by his father and uncle with great reluctance. He started to believe himself as disable and enjoyed school absenteeism, special attention of the family members and the hospital staff. Thus, the child indirectly helped in the deception to protect himself against fear of abandonment. Earlier studies suggest that many victims of MSBP become Munchausen patients later in life by learning to identify with illness and using it as means of expression and communication.\(^4\) Therefore, early recognition and intensified management is must.

The Royal College of Pediatrics and Child Health suggest a new nomenclature, i.e., fabricated or induced illness by carers, shifting the focus to child abuse that happens in medical setting.\(^10\) It minimizes harm to the child regardless of the motivation of the perpetrator.\(^11\) Child protection services and legal services may be involved depending on the severity of MSBP. We made use of the familial support system i.e., the mother, so as to safely place back the child with the family. It is concluded that the medical professionals should consider the possibility of MSBP along with their primary differential diagnosis, rather than diagnosis by exclusion. Compulsory psychiatric admission is recommended once the diagnosis has been made to initiate treatment at the earliest.
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