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
Munchhausen’s syndrome is a very rare disease first described in 1951 by Richard Asher, who named the disorder after Baron Munchhausen, a man famous for his wild fabricated tales of travels.1 Today, Munchhausen’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 Munchhausen’s syndrome.

Case Report
We present a case of a 41-year-old male Caucasian opera singer. He presented at our psychiatric emergency ambulace 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
pseudologia
Furthermore, the variations in the reported personality were the major criteria. Hopping and a very distinct narcissistic personality disorder was 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 (system-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 |
References
1. Asher R. Munchausen syndrome. Lancet 1951;1:339-41.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. St. Louis: American Psychiatric Association; 2013.
3. Prakash J, Das RC, Srivastava K, et al. Munchausen syndrome: playing sick or sick player. Industr Psychiatry J 2014;23:68-70.
4. Schlesinger RD, Daniel DG, Rabin P, Jack R. Factitious disorder with physical manifestations: pitfalls of diagnosis and management. South Med J 1989;82:210-4.
5. Wittchen HU, Zaudig M, Fydrich T. SKID Strukturiertes Klinisches Interview für DSM-IV Achse I und II. Göttingen; Hogrefe; 1977.
6. Meropol NJ, Ford CV, Zaner RM. Factitious illness: an exploration in ethics. Perspect Biol Med 1985;28:269-81.
7. Eastwood S, Bisson JI. Management of factitious disorders: a systematic review. Psychother Psychosom 2008;77:209-18.
8. Michel L, Lang JP. Benzodizepines and forensic aspects. Encephale 2003;29:479-85.
9. Rabovsky K, Stoppe G. Die Rolle der Psychoedukation in der stationären Behandlung psychisch Kranker. Nervenarzt 2006;77:538-48.