Munchausen syndrome refers to those with severe and chronic forms of factitious disorders. Munchausen syndrome is characterized by repeated fabrication of clinically convincing simulations of disease, feigning acute medical or surgical illness and giving false and fanciful information about their medical and social background. Such patients often undergo painful or risky tests and surgeries in order to obtain the sympathy and special attention given to people who are truly ill. A review of records from 2008 to 2016 reported that the incidence of factitious diseases was 3.71 per 100,000 in Germany and 3.18 in Norway with almost equal gender distribution. Data on the population-level incidence of Munchausen syndrome are lacking and existing case reports are mostly based in developed countries.

While most physicians are aware of factitious disorders and Munchausen syndrome, it is often misdiagnosed for long periods of time. We present a case of Munchausen syndrome in a middle-aged male who had visited multiple hospitals and was extensively evaluated for 4 years for recurrent bleeding from the right ear, hearing loss, abnormal jerky movement of limbs and poor sleep. The patient was initially evaluated and managed by the ENT team and only after 4 years did the patient have access to a psychiatrist. We discuss this case in the background of a free health care system in Bhutan, a lower-middle-income country with a population of 0.7 million and only three psychiatrists, and the need for timely access to mental health professionals in the early part of the disease course.

Case report
A 46-year-old male, who works as an instrument calibrator in a private company, presented to a district hospital 4 years ago with a history of fall at workplace. He had reported a loss of consciousness and bleeding from the right ear and was managed symptomatically. Following his discharge, he had multiple hospital visits with complaints of recurrent bleed...
While in the ward, he had abnormal behaviours such as staring and a cardiology review with 2D echo showed normal studies. Magnetic resonance imaging (MRI) brain, cerebral angiogram, electroencephalogram and video telemetry ruled out seizures. Bladder or bowel incontinence. A neurology review with elec-
consciousness and no tongue bite, frothing, rolling of eyeballs, or reported jerky movement of all four limbs with preserved con-
bleeding from his right ear.

Extensive ENT review, he continued to complain about any undiagnosed pathology. Despite normal findings on a normal study. He underwent a cortical mastoidectomy to rule out any undiagnosed pathology. Despite normal findings on extensive ENT review, he continued to complain about bleeds from his right ear.

During his hospital stay, he had difficulty in sleeping and reported jerky movement of all four limbs with preserved consciousness and no tongue bite, frothing, rolling of eyeballs, or bladder or bowel incontinence. A neurology review with electroencephalogram and video telemetry ruled out seizures. Magnetic resonance imaging (MRI) brain, cerebral angiogram and a cardiology review with 2D echo showed normal studies. While in the ward, he had abnormal behaviours such as staring at objects and refusing to take medications. What drew our attention was that such attacks were more frequent whenever he was advised discharge from the hospital.

Although he was using a hearing aid, in an unusual observation, he was able to hear soft voice and when the physician talked from behind. Pure tone audiometry showed bilateral profound sensorineural hearing loss out of proportion to his ability to communicate without lip reading. A battery of tests with the otoacoustic emission, acoustic reflex, and brainstem evoked response audiometry with tone bursts suggested only high-frequency hearing loss.

He had separated from his wife 5 years ago and had financial problems educating his three children. While he had multiple hospital visits and admissions, he continued to receive a salary from his employer. Based on the clinical history, examination, extensive evaluation and follow-up over 4 years and a psychiatry review, a diagnosis of Munchausen syndrome was made. He was followed up with monthly visits at the psychiatry outpatient clinic and did not have recurrent ear problems.

**Discussion**

This is a case of Munchausen syndrome confirmed 4 years after the presentation and multiple hospital visits, admissions and extensive evaluation. He had initially presented to a district hospital and was subsequently referred to the National Referral Hospital. This case reflects the prolonged period of risk endured by the patient and wastage of healthcare resources. During his 4-year follow-up, he was exposed to risks of iatrogenic complications arising from unnecessary tests and treatments. The cost of all his medical visits, investigations, procedures and hearing aid were borne by the free healthcare system of the country.

Persons with factitious disorders deliberately simulate or exaggerate symptoms of an illness in themselves and can mislead healthcare workers. Factitious disorder differs from malingering in that it is not done for obvious external rewards such as financial gain, housing, or medications. The Diagnostic and Statistical Manual of Mental Disorders (fifth edition) diagnosis requires the following: falsification of physical or psychological signs or symptoms or induction of injury or disease associated with identified deception; the individual presents as ill, impaired or injured; the deceptive behaviour is evident even in the absence of obvious external rewards; and the behaviour is not explained by another mental disorder such as delusional disorder or another psychiatric disorders.

People with factitious disorders have an inner need to be seen as ill or injured, but not to achieve a concrete benefit, such as a financial gain. They present to all medical specialties. While it was earlier believed that a vast majority of patients with factitious disorder are female, a review of records from Germany and Norway reports a nearly equal gender distribution. The average age of presentation is between 30 and 40 years of age, and like other
patients with factitious disorders, they tend to have either
direct or peripheral knowledge of the medical field. Munchausen
syndrome was described initially in adults, it is
reported by proxy in children. Patients with Munchausen syndrome commonly have a
history of multiple hospitalizations, usually for acute problems. Because of multiple presentations and diagnostic tests they
undergo, the physical examination generally reveals multiple
bodily scars. Unlike patients with factitious disorders who present with what appears to be normal medical problems, patients with Munchausen syndrome present with unusual and
dramatic presentations and histories that are often inconsistent
with physical examination or laboratory evaluations. They
offer no resistance or concerns when diagnostic procedures are
offered, no matter how invasive they may be.

While the most common falsified symptoms include abdominal pain, arthralgia, chest pain, bleeding, diarrhoea, haematuria and seizures, the two main ENT regions involved are the face and ear. The ENT specialist should suspect Munchausen syndrome in patients with strange and
long-lasting symptoms, so as to avoid misdiagnosis and
unnecessary harmful treatments that waste time and resources
in the free healthcare sector.

Patients with factitious disorders are often treated by mul-
tiple clinicians. Diagnosis requires exclusion of unusual
presentation of common disorders and psychiatric evaluation
to exclude borderline personality, conversion, delusional and
somatoform symptom disorders. The management requires a
multidisciplinary team: physicians and surgeons to provide
acute emergency care, psychiatrists to evaluate the men-
tal health and support from family and social workers. All
members of the patient’s multidisciplinary team should be
informed about the diagnosis of a factitious disorder and the
treatment plan. The patient should be monitored for the risk
of self-injury or suicide. The diagnosis should be discussed
with the patient and the family members in a manner that
minimizes humiliation to the patient. Specific therapy
involves supportive psychotherapy or cognitive-behavioural
therapy and engagement of patients in the treatment.
Antipsychotics or antidepressants are not beneficial. However, there is an absence of sufficient robust data on the
effectiveness of any management technique for factitious
 disorders. The prognosis for factitious disorders imposed
on self is poor and requires long-term follow-up.

Munchausen syndrome poses diagnostic challenges espe-
cially in settings where access to specialist mental health prac-
titioners are limited. The incidence of Munchausen syndrome in
developing countries is not known and the patients are often
misdiagnosed and do not receive appropriate care. This is
particularly concerning when access to mental health care is
limited in many developing countries. Bhutan, a country in the
eastern Himalayas, is one such example where there are only
376 doctors among which only three are psychiatrists.
As the
forms of Munchausen syndrome change over time, such as
a case of factitious movement disorder with a forged gene
mutation testing reported in 2017 and the symptoms of dry
cough, sore throat and anosmia mimicked during the COVID-
19 pandemic, this report is a timely reminder for the need to
improve access to mental health professionals and cross-disci-
plinary collaboration in patient care.

Conclusion
Factitious disorders and Munchausen syndrome should be
considered in patients with characteristic history and discre-
pancies with physical examination and investigative
findings. Early investigation and confirmation of possible
factitious disorder reduces harm to the patient and saves
health resources.

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