

Munchausen by Proxy Syndrome Associated with Fecal Contamination: A Case Report



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SUMMARY

Factitious disorder imposed on another, also known as Munchausen Syndrome by Proxy (MSBP), is a serious form of child abuse that is difficult to diagnose. In general, signs and symptoms are fabricated or produced by the mother or the caregiver. Delay in diagnosis may cause serious morbidity and mortality. Here, we present the case of an 18-month-old boy who was admitted to the Paediatric Infection Clinic with a diagnosis of acute gastroenteritis. When on intravenous fluid therapy, he developed high fever and subsequently, polymicrobial growth was determined in his blood. He was later diagnosed with MSBP. Despite being a rare condition, MSBP is a disorder that is often overlooked and may have fatal outcomes. Early diagnosis is very important in this disorder, which is considerably difficult to diagnose. In suspected cases, interdisciplinary team work is necessary to prevent adverse consequences.

Keywords: Munchausen syndrome by proxy, infant, polymicrobial bacteraemia

INTRODUCTION

Factitious disorder imposed on another, also known as Munchausen Syndrome by Proxy (MSBP), is a rare type of child abuse that is difficult to diagnose. This disorder, first described in 1977 by Roy Meadow, is characterized by a caregiver's fabrication of disease symptoms in an individual under his/her care or treatment. In this disorder, the caregiver is generally the mother, and the child is the care receiver, although in some cases, the father or another person have been reported as being the caregiver (Feldman and Hickman 1998, Makar and Squier 1990, Richardson 1987, Sheridan 2003). In 85% of these cases, the caregiver was reported to be the mother (McClure et al. 1996). Munchausen syndrome presents in approximately 1.3% of all hospitalized patients and constitutes 0.04% of the child abuse cases (Abeln and Love 2018). In a multicentre study on child abuse in Turkey, a total of 593 factitious disorder cases were reported between 2000-2006 and five of these cases (8%) were found to be MSBP (Ağırtan et al. 2009). This study highlights the importance of MSBP as an uncommon child abuse with frequently missed diagnosis.

Factitious disorder was first included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980. In DSM-5, Factitious Disorder (FD) was placed in the group of "Somatic Symptoms and Related Disorders". Two different forms have been described as Factitious Disorder Imposed on Self and Factitious Disorder Imposed on Another (previously Factitious Disorder by Proxy) (American Psychiatric Association-APA 2013). Munchausen Syndrome can be differentiated from simulation of disease as motivation to be sick and receive attention and care with a recurrent and chronic nature. Continuous and unnecessary examinations and hospitalizations to exclude the organic aetiology of symptoms lead to loss of function in the patient and loss of time and materials in the health system (Karakoç Demirkaya et al. 2016).

Here, we report the case of an 18-month-old male patient with a diagnosis of acute gastroenteritis who had a high fever and polymicrobial growth in blood culture while receiving parenteral fluid therapy.

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CASE

The 18-month-old male patient was brought to the Paediatric Emergency Department on the day of developing complaints of vomiting and diarrhoea. After inability to tolerate oral intake and continuation of vomiting under follow-up at the emergency services, he was hospitalized in the Paediatric Infection Service. The patient with normal levels of acute phase reactants and biochemical parameters at the time of admission was followed up with intravenous (iv) fluid treatment. Despite the improvement of diarrhoea and vomiting on the 5th day of hospitalisation, the patient had episodes of fever exceeding 38 °C. The patient was re-evaluated for fever and the laboratory tests were repeated. Since the focus of fever could not be determined, blood culture was taken and a single dose (80 mg/kg/day iv) ceftriaxone treatment was started with the preliminary diagnosis of sepsis and the patient was placed at the sepsis clinic. As the fever persisted at the 72nd hour of iv ceftriaxone, the treatment was switched to piperacillin-tazobactam (300 mg/kg/day, 4 doses). *Aeromonas hydrophila* and *Klebsiella oxytoca* growth occurred in blood cultures with sensitivity to the antibiotic used and therefore the same treatment was continued. Since different species of gram-negative enteric bacilli kept growing in the blood culture during follow-up, antibiotic treatment was changed to meropenem (100 mg/kg/day, 3 doses). The patient was further investigated for local infection focus and infective endocarditis.

There was no indication of pathology in echocardiography (ECO) evaluation and abdominal ultrasonography. The patient's ongoing fever was accompanied by occasional diarrhoea. The patient's clinical and laboratory findings deteriorated, and bone marrow aspiration was performed with the preliminary diagnosis of macrophage activation syndrome. Consultation was sought with the Paediatric Haematology, and bone marrow findings were found consistent with sepsis. The patient was twice given intravenous immunoglobulin treatment (1 g/kg). In terms of infective endocarditis, ECO was repeated but pathology was not detected. Thoracic and abdominal computed tomography for abscess focus detection was found to be normal. Hepatosplenomegaly, neutropenia, thrombocytopenia and anaemia developed during the follow-up period and multiple transfusions were performed for support. Whereas the fever and growth of different gram-negative enteric bacteria in blood cultures of the patient persisted with worsening of the clinical status on the 45th day of hospitalisation, the mother appeared unconcerned and kept inquiring about the blood culture results.

Child abuse was suspected since the mother did not allow change of patient companion and repeatedly requested medical supplies such as syringes and needles from the service nurses. The mother was referred to the Department

of Psychiatry. The issued psychiatry report stated that staying in the hospital had been convenient for the mother whose family and social condition had not been good. This statement supported suspected MSBP. The patient was evaluated as a case of child abuse and reported to the social services unit of our hospital. Official procedures were initiated by a social service expert. The parents were convinced on the change of patient companion to allow the mother a needed rest. After changing the companion, the patient's blood culture growth and fever ceased, and the clinical data improved.

The patient was discharged after 2 weeks of observation and put under follow up control at the Paediatric Infection Polyclinics. The mother was admitted to the psychiatry clinic for investigation where she admitted to injecting iv faecal contaminants to her son. During her stay it was learned that she was a 28-year old housewife who had left elementary school at the third grade with social support problems. She was the youngest of six siblings and not being able to remember her father, whom she had lost at the age of 1, had been a source of sorrow for her. Her mother had been a very hardworking woman, who had made a "superhuman effort" to raise them all by herself. From an early age, she had been employed as an agricultural worker. Since the age of 17 she had been living with her husband, mother-in-law, father-in-law, sister-in-law and brother-in-law. She perceived her mother-in-law as dominant and intrusive but spoke with affection about the kindness and support of her father-in-law whom she saw as her own father. She had two sons aged 9 years and 18 months. Her elder child was raised by her mother-in-law and was closer to her rather than the mother. She felt sorry that she could not take care of him as she wanted. She complained about the difficulties of living as an extended family, with frequent crowds of visitors, serving them as the bride of the house and endless housework which prevented taking proper care of her children. She said that it had been good to be alone with her younger son in the same room in the Paediatric Service and that she felt happier in the hospital than at home. She did not have a personal or family history of psychiatric disorder.

In here psychiatric examination her mood was sub-depressive, her affect was compatible with her mood, her psychomotor activity and energy were natural, her thought process and contents were natural, she did describe signs of mania or hypomania. Her sleep and appetite were normal. Her psychometric scale scores were 20 on the Brief Psychiatric Rating Scale (BPRS), 12 on the Hamilton Depression Rating Scale (HAM-D) and 4 on the Young Mania Rating Scale (YMRS). On the Rorschach test for psychometric evaluation, "the ability to assess reality has been preserved and passive-aggressive personality traits" were detected (Erkoç et al. 1991, Akdemir et al. 2001).

Despite scoring 70 points on the IQ test, she was considered to be within normal limits or at the level of dull normal intelligence, given her clinical assessment and social functioning. During hospitalisation in the psychiatry clinic with the diagnosis of Major Depressive Disorder, sertraline was started at 25 mg/day and was titrated to 100 mg/day. Interviews were made with the patient and the family. With the consent of the patient, her spouse was interviewed; the diagnosis on the patient and the causes were discussed. He was recommended to accompany his wife during the continuation of regular outpatient follow up visits and to give her support in the family. Regular outpatient follow-ups, twice a month to start with and subsequently once a month, were continued for approximately one year with some visits in the company of the husband. Depressive symptoms of the patient regressed, her husband provided intensive support and her mother-in-law was more understanding. Her responsibilities at home were decreased, and she was allowed to spend plenty of time with her younger son, even though she was not left alone with him. The patient also frequently expressed her satisfaction with these changes. Despite not moving to a house of their own as promised by her husband, the patient stated that she felt more peaceful after the change in the dynamics within the family. She expressed herself more clearly than before and felt better with the open support of her husband and father-in-law. The patient discontinued outpatient follow-up visits for eight months but continued to use her medication. About 1.5 years after the last polyclinic consultation, the patient's husband reported to the psychiatrist that her wife and children were fine and that they no longer had any problems. Finally, the patient presented to the psychiatry outpatient clinic with the intention of discontinuing the medication. The patient who was in remission was recommended to gradually reduce the sertraline dose to 50 mg/day and to visit the outpatient clinic after one month.

DISCUSSION

In the literature, reports on MSBP are mostly case presentations. Although MSBP is considered as a rare disorder, the difficulty of diagnosis and frequent misses have been emphasized. On the other hand, mortality incidence in MSBP was reported to be in 6-10% range (Blyt et al. 2007). Rosenberg (1987) described four diagnostic characteristics for MSBP which entered the literature after two cases described by Meadow (1990). These were:

1. Patient's clinical complaints are produced or imitated by the caregiver;
2. There is a history of frequent medical evaluation and treatment;

3. Caregiver is resistant to providing information about the aetiology of the disease;
4. Symptoms disappear when the caregiver and the patient leave apart (Rosenberg 1987).

There are few case reports on MSBP from Turkey (Foto-Özdemir et al. 2013, Türkmen et al. 2012, Foto-Özdemir et al. 2015). However, the awareness of the forensic status of MSBP as a form of child abuse has increased in recent years (Ağırtan et al. 2009, Küçüker et al. 2010).

Cases of MSBP with bacteraemia secondary to intravenous catheter contamination are very rare and limited to only 19 cases in the literature (Blyt et al. 2017). Sheridan (2003) reported that 1.8% of the 451 studied cases of MSBP had paediatric sepsis and the responsible pathogen was frequently identified as polymicrobial and enteric. Similarly, in our case, the gram-negative sepsis attacks could not be controlled by antibiotic treatments due to the continuous intravenous faecal contamination by the mother. The most common clinical manifestations in the MSBP by the caregiver are in the form of epileptic seizures, apnoea, vomiting-diarrhoea, asthma and allergic reactions (Rosenberg 1987). In the case presented here, a history of frequent infection in the patient under treatment, the inability to detect any aetiological evidence to explain the clinical state during hospitalisation, growth of faecal flora in the recurrent blood cultures, observation by the treatment team of concealment by the caregiver mother of the material required for the culture investigations, refusal by the caregiver mother of changing the patient's companion, rapid recovery in the patient's clinical condition after changing his companion and cessation of bacterial growth in blood cultures supported the diagnosis of MSBP.

Another important diagnostic feature in MSBP is the voluntary discovery of psychological or physical symptoms in an individual under the care of another individual, without the aim of any secondary gain. The most important motivation in MSBP is the adoption of the patient role caused by the caregiver. Also, the most important condition that should be evaluated in differential diagnosis is simulation when the predominant motivation in feigning psychological or physical symptoms for secondary gain (APA 2000). In our case, lack of motivation to obtain secondary gain by the caregiver in causing the physical symptoms in her son eliminated the diagnosis of simulation. Although there is not definitive information in the literature about the aetiology of MSBP, childhood traumatising of the caregiver by being neglected and the pathological relationship between the caregiver and the child were emphasized (Waller 1983).

According to the model proposed by Libow and Schreier (1986), caregiver mothers in MSBP cases are divided into 3 groups including "help seekers", "doctor addicts" and "active inducers". The most characteristic feature of the help seeker

mother is to produce symptoms in order to receive help to cope with her feelings of inadequacy, anxiety, depression and burnout as a parent. Help seeker mothers are more likely to be the subjects of domestic violence, to have more marital problems and a history of unintended pregnancy.

Doctor addict mothers strongly believe that their children are really sick and almost never believe the evidence to the contrary. Libow and Schreier (1986) described the doctor addict mothers as insecure and angry, pointing to the high likelihood of personality disorder in this group.

Mothers of the active-inducing type cause serious symptoms to appear in their children but assume to be very concerned and compassionate when in contact with the treatment team (Libow and Schreier 1986). On the basis of this classification, the caregiver mother in the case of our patient appears as a help-seeker, who was living in a large family with the burden of all household chores and without support from her husband and mother-in-law, and who stated that she was not given the opportunity to mother her children. She said that her mother-in-law raised her first child and she wanted to take care of the second one herself, but she could not do it at home, and felt better being alone in the hospital room with her baby.

After cooperation of her husband, achieved by the treatment team during her stay at the psychiatry clinic and at follow-up controls at the outpatient clinic, the patient received support in the family and started to express her wishes and aggression more easily after reducing the conflict with the family. Hence, the recurrence of the MSBP symptoms was prevented after completion of the therapy. This case may be important as a relatively mild case with a positive outcome in comparison to the very severe and fatal cases of MSBP described by Küçüker et al. (2010). It is reported in the literature that the diagnosis of MSBP should be considered in treatment-resistant cases with unclarified aetiology, the presentation of a disease not compatible with the clinical findings, when the clinical conditions of the patient improve with removal of the caregiver and in cases of sudden infant death in the family (Jones et al. 1986).

Although MSBP is a rare condition, it is a disorder that is often overlooked and may cause fatal outcomes. Early diagnosis, although very difficult, is also very important in this disorder. In suspected cases, an interdisciplinary team work is necessary to prevent adverse consequences.

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