Factitious Gastrointestinal Bleeding: A Case Of Münchhausen Syndrome.

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Citation

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Abstract

Münchhausen syndrome is a psychiatric disorder characterized by patients presenting with dramatic symptoms but with inconsistent histories. Presentations of Münchhausen are varied and very few cases of patients presenting as factitious gastrointestinal bleeding with blood in stools and abdominal pain have been reported. We report a case of a young female presenting with severe abdominal pain and bloody diarrhea. The unrelenting symptoms led to an extensive workup which was negative and prompted reconsideration in approach to the patient's management. A thorough search of her room was performed which revealed four syringes partially filled with blood.

INTRODUCTION

Münchhausen syndrome is named after a German baron, Karl Friedrich Hieronymus Freiherr von Münchhausen. Born in 1720, Münchhausen joined the Russian military and fought against the Turks. Upon return, the baron supposedly told a number of outrageous tall tales about his adventures. The modern history of Münchhausen syndrome's syndrome began in 1951, when a clinician Richard Asher described case reports of patients seeking admission through feigned symptoms while embellishing their personal history [1] . Since the original description of Münchhausen syndrome, its presentation has evolved into a wide spectrum that includes diarrheal states, hypoglycemia, hyperthyroidism, fever of unknown etiology, hemorrhagic diathesis and many other disorders [2] . Factitious gastrointestinal bleeding is very uncommon and there have been very few cases reported in the literature till date [3-8] .

CLINICAL COURSE

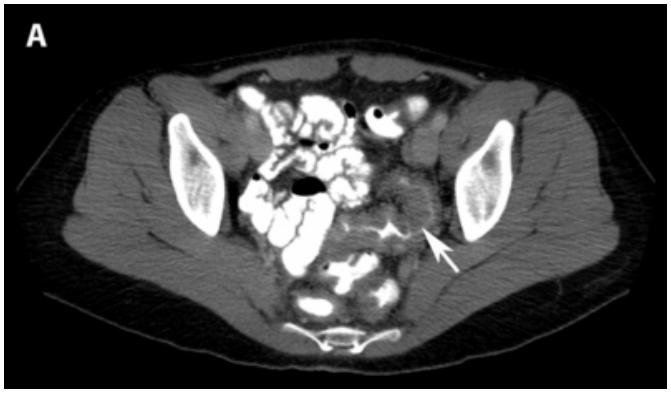
A 30-year-old Caucasian female presented to the emergency department (ED) with one day history of severe cramps, abdominal pain and five episodes of bloody diarrhea. There was no history of fever, chills, nausea, vomiting or tenesmus. The patient reported a history of ulcerative colitis (UC) diagnosed four years ago at an outside hospital. The patient reported her UC to be quiescent requiring no medications. She also reported a history of right oophorectomy for ovarian torsion and endometriosis. Review of past medical records showed multiple visits to the ED over the past seven years for various reasons including toothache and abdominal pain. Four of these visits led to an in-patient workup of abdominal pain, which included colonoscopy, flexible sigmoidoscopy, multiple computed tomograms (CT) of the abdomen and abdominal ultra sounds, without demonstration of any significant pathology.

Physical examination showed a pleasant, well-nourished female writhing in pain. Vital signs were remarkable for a heart rate of 110 beats per minute. She had no pallor, lungs were clear and heart was regular without any murmurs. Abdomen was soft, non-distended with significant tenderness in the left lower quadrant without any guarding or rebound. Rectal exam showed formed brown stools with streaks of bright red blood and a proctoscopic exam revealed no source of bleeding. Pelvic examination in the ED revealed a closed os with left adnexal tenderness and no blood in the vaginal vault.

Laboratory studies on the day of admission revealed a normal chemistry, liver function tests, amylase and lipase. Her hemoglobin was 11.0 gm/dl (normal: 12-16 gm/dl) with a mean corpuscular volume (MCV) of 82.4 fl (normal 81-99 fl) and her white blood cell count was 4,000 cells/µl (normal: 4,000-12,000 cells/µl) with a normal differential count. A trans-vaginal ultrasound showed a normal pelvis with a surgically removed right ovary. A CT scan of the abdomen and pelvis performed in the ED revealed sigmoid wall thickening consistent with sigmoid colitis (Figure A).

Figure 1

Figure A: CT scan demonstrating thickening of the wall of the sigmoid colon consistent with colitis



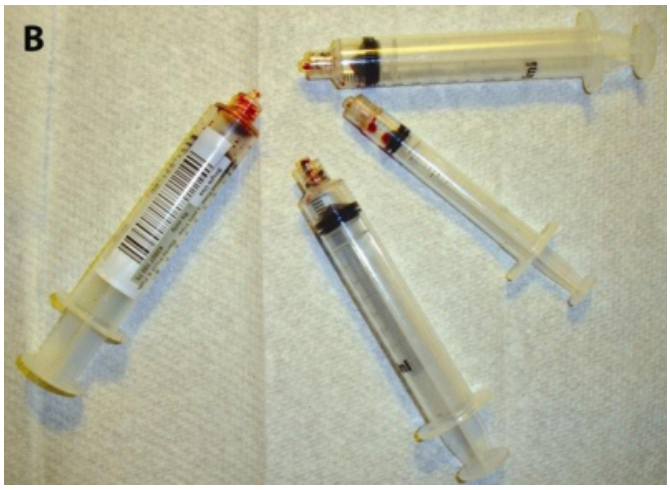
The patient was admitted for pain control and further diagnosis and management of her colitis. She was kept fasting and started on intravenous antibiotics, narcotics and rectal mesalamine. Gastroenterology was consulted and a flexible sigmoidoscopy revealed mild edema and some friability in the sigmoid colon with small amounts of bright red blood. On the third day of admission, the patient reported vaginal bleeding and persistence of her bloody diarrhea and severe abdominal pain unrelieved by antibiotics and mesalamine. Stool studies for ova, parasites, white cells and stool culture were unrevealing and biopsy of the rectum returned normal without any pathological evidence of UC. Since the patient continued to report abdominal pain and five to ten episodes of bloody diarrhea every day, a colonoscopy was performed which showed mild edema and large amount of blood in the rectum and distal sigmoid with no obvious bleeding lesions; normal mucosa from sigmoid to the terminal ileum was noted.

On day five of admission, due to lack of adequate intravenous access, a peripherally inserted central catheter (PICC) was placed. With a definitive diagnosis still elusive, the patient underwent an upper gastrointestinal series with small bowel follow-through and a Meckel's scan, both of which were inconclusive. Despite the large amount of presumed gastrointestinal blood and fluid losses, the patient's complete blood counts remained stable and she did not demonstrate any physical evidence of dehydration or hemodynamic instability. On the request of the attending physician, the nursing staff confirmed the presence of blood in the stools.

On day ten of hospitalization, with continuing abdominal pain and bloody diarrhea, the patient had a repeat flexible sigmoidoscopy, which demonstrated fresh blood with clots in the distal rectum and brown heme negative stools in the sigmoid colon. At this point, the medical team reconsidered the approach to the case in light of the negative workup and the patient's dramatic presentation of symptoms coupled with multiple visits to the ED in the past. While the patient was recovering from sedation given during the procedure, a thorough search of her room was performed which revealed four syringes partially filled with blood (Figure B), carefully hidden under her bed. It was presumed that the patient had drawn blood from her PICC line and inserted it rectally using the syringes and also poured some blood into the commode admixed with stools.

Figure 2

Figure B: Hidden syringes discovered in the room of the patient



Before confronting the patient, the hospital's ethics committee and patient relations were made aware of the suspicion of factitious illness. With great reluctance, the patient admitted drawing blood from her intravenous (IV) infusions and later her PICC line and injecting it into her rectum and vagina. However, the patient refused a consultation with psychiatry and left the hospital against medical advice. This clinical picture is consistent with a diagnosis of Münchhausen's Syndrome.

DISCUSSION

This case demonstrates an interesting and rare presentation of Münchhausen syndrome as a factitious gastrointestinal bleeding. Patients with Münchhausen syndrome, a sub-type of factitious disorder (FD), present with a dramatic but an inconsistent medical history. They have extensive knowledge of medical terminology, are very eager to have medical tests and surgeries done and have a history of seeking treatment at many different hospitals and in the

same hospital under different physicians [9] .

Diagnosis of FD is typically made late; after all other diagnostic possibilities have been exhausted. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV) requires that the following three criteria be met for the diagnosis of Factitious Disorder (FD): (I) intentional production of physical or psychological signs or symptoms, (II) motivation for the behavior is to assume the sick role and (III) absence of external incentives for the behavior [10] .

The exact cause of factitious disorder is unknown, but some theories suggest that a history of neglect as a child or a history of frequent illnesses that required hospitalization may be factors in the development of the disorder.

Although room searches remain a controversial issue, some hospital attorneys have suggested that a room search could be justified both legally and ethically if the patient's life is at risk [11] . With respect to our patient, a room search to obtain direct evidence of self-injury was the most expedient approach to make an accurate diagnosis. The patient herself had provided a wealth of diagnostic clues. Her symptoms were incongruent with her physical examination, blood tests and diagnostic procedures. Interestingly, the patient did not report a diagnosis of UC on the past admission which was only one year ago and the patient told the house staff that she worked as a bartender but according to previous records, she worked in a local hospital.

Once the diagnosis of FD has been established, the question often arises as to whether one should confront the patient. Confrontation of the patient has been controversial, and certainly if confrontation is felt to be appropriate, it is best done after some alliance with the patient has been established. Moreover, the team can communicate that they will continue to care for the patient by arranging for outpatient medical and psychiatric care once medical illness is ruled out. The physician should emphasize referral to a psychiatrist to provide support and stress management. Despite all these methods, most patients refuse psychiatric evaluation and leave the hospital against medical advice. In general, the prognosis for patients with Münchhausen syndrome appears to be poor. A flexible and creative approach that emphasizes consistency and regular outpatient psychiatric care has been associated with the most success.

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