Case Report

A Case of Munchausen by Proxy: A form of Child Abuse

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Author's Contribution

[3] *Conception of study*
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Abstract

Munchausen syndrome by proxy (MSBP), also known as medical child abuse, is a special form of child abuse in which a parent or caregiver fabricates an illness in their child in order to meet his or her own emotional needs via the treatment process. MSBP was first described in 1977 by paediatrician Roy Meadows, who identified parents who invented illness stories about their children and even made up physical signs.[3] MSBP has been termed as a factitious disorder by proxy in the Diagnosis and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[4]

Since diagnosing MSBP is a difficult task for any health professional, diagnostic criteria have been defined by Meadow and Rosenberg.[5] Family members or caregivers, usually, the mother of the child can make up for almost any disease, leading to multiple hospital visits, various treatments, and a high recurrence of the illness.

The perpetrator is usually a mother with mental disorders.[5] Once the diagnosis is made, it is important to start psychiatric treatment as early as possible while separating the child from the perpetrator.

Keywords: Case; Munchausen syndrome by proxy; child abuse.

Case

We describe the case of a 2-month-old boy who presented to our hospital, suspected of being a victim of Munchausen syndrome by proxy of his mother.

His first visit to our hospital was to the paediatrician's clinic. His mother was 37 years old, with two previously healthy girls. She was a qualified paediatrician herself, who was currently on maternity leave, while the father worked abroad. The mother gave the history that he was born at term via a spontaneous vaginal delivery, with a normal postnatal course. He was described as having nasal congestion since the second day of life for which she self-prescribed antibiotics. On the 9th day of life, he developed a staring gaze for which he was taken to the hospital and treated for meningitis after a lumbar puncture. He was well in between till 3 weeks before his presentation to our hospital. He again had upper respiratory illness symptoms for which he visited several paediatricians and had received multiple oral antibiotics while being treated for pneumonia. For the last 1 week, he reportedly ran a high-grade fever and a croupy cough with stridor. He received intravenous 3rd generation cephalosporin as well as inhaled and intravenous corticosteroids without much improvement. He was currently on three intravenous antibiotics.

In the paediatrician's office, his vital signs were within normal range, heart rate of 151 beats/min, oxygen saturations (SpO2) 98%, and he was not in distress. Weight was 5.8kg, length 61.5cm, and head circumference 41cm, all plotted on the growth curve between 50-75th centile for age. The rest of his physical exam was normal, except for oral thrush noted. The paediatrician's impression was a viral illness. Chest X-ray and laboratory investigations including a complete blood count, C-reactive protein, and blood culture were advised.

The next day the mother came to the ER complaining that the child was lethargic and edematous. She was concerned that his current symptoms could be a manifestation of cardiac failure. On examination, a playful child was seen, with the same weight as the previous day, 5.8kg. His vital signs were normal, heart rate of 125 beats/min, respiratory rate of 40 breaths/min, SpO2 97%, and blood pressure of 120/65 mmHg. There were no signs of respiratory distress or heart failure. Laboratory investigations from the previous day were reviewed which were all within normal limits, pending blood culture. Chest X-ray showed mild hilar infiltrates on the right side. The mother was reassured about her concerns, and admission to the hospital was offered for observation of the child.

At the mother's insistence, the child was admitted to Pediatric ICU (PCIU) for close monitoring. Echocardiography and electrocardiogram were done which were normal for age. Overnight, the mother called the staff and doctors almost hourly with one concern or another, which was documented by them. According to the mother, during her PICU stay the child had cyanotic spells, cold and clammy skin, drug reaction, abnormal readings of heart rate, and blood pressure on the monitor, none of which was corroborated by the staff who repeatedly examined the patient. At 3.30 am, the PICU consultant on call examined the child due to maternal concerns. However, the mother remained unsatisfied. Her behaviour became increasingly disruptive. She even confiscated the medical chart of the patient and documented her findings. She demanded self-prescribed medications for her child.

On further enquiry from the father, it was revealed that the mother had a history of postpartum depression after the delivery of one of her previous children. She also had a history of panic attacks. Her concern for the child had worsened since the departure of the father who returned to his workplace abroad. The case was discussed with the hospital Psychiatry team and a formal assessment was planned, as well as separation of the child from the mother while in hospital. However, the mother refused to cooperate and had the child discharged against medical advice.

Discussion

Munchausen syndrome by proxy (MSBP), also known as medical child abuse, is a special form of child abuse in which a parent or caregiver fabricates an illness in their child in order to meet his or her own emotional needs via the treatment process.[1,2] MSBP was first described in 1977 by paediatrician Roy Meadows, who identified parents who invented illness stories about their children and even made up physical signs.[3] MSBP has been termed as a factitious disorder by proxy in the Diagnosis and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[4]

Although rare as compared to other types of child abuse, the incidence of MSBP is reported as 2-2.8/100,000 in children younger than 1 year of age with the average age at diagnosis between 20 months

to 3.25 years.[6] The reported mortality rate is as high as 6-10%.[5,6]

Diagnosing MSBP can be a challenging task for any health professional. Family members or caregivers, usually the mother of the child, can make up for almost any disease, leading to multiple hospital visits, various treatments, and a high recurrence of the illness. The most common method is misleading the health professionals about the child's symptoms. The most common symptoms are haemorrhage (44%), loss of consciousness (19%), apnea (15%), recurrent diarrhea (11%), recurrent vomiting (10%), and redness (9%). In severe cases, the child may even be poisoned or suffocated.[5] These assaults are typically compounded by painful procedures and expensive treatment in an effort to diagnose and treat an apparently complicated and elusive medical condition.[2]

The symptoms at presentation of the child can occur in the course of an actual illness, however, the suspicion of MSBP usually occurs in the setting of a misalignment in the cause, severity, and persistence of the child's symptoms. This requires a detailed history from the caregiver, to try and elucidate an understanding of the underlying concerns. Paediatricians'' diagnoses are dependent on the detailed medical story from the child's caregiver, but in these cases, this most important is invalidated.

To aid the diagnosis, criteria have been defined by Meadow and Rosenberg as follows[5]:

1) The disease must have been made up by parents or by those who replace the parent
2) Symptoms are often presented to require more than one recognition. The parent does not accept the etiology of the disease
3) Disease indications and acute symptoms end when the child leaves the parent.

Warnings signs that may point towards a diagnosis of Munchausen syndrome by proxy include[2]:

1) Persistent or recurrent illness that cannot be explained.
2) Discrepancies between clinical findings and history
3) Symptoms occur only in the presence of the perpetrator
4) Symptomatology or treatment course is clinically inconsistent
5) The diagnosis of Munchausen syndrome by proxy is more likely than any other clinical working diagnosis
6) The perpetrator encourages painful medical tests for her child, has previous medical experience, yet may seem less concerned about the actual health of the child
7) Family history of sudden or unexplained infant death

The perpetrator is usually a mother with mental disorders.[7] Chronic somatoform disorders or personality disorders have been implicated.[7] Evaluation of previous medical records of the patient and other siblings, as well as a detailed social history, may help identify an illness pattern.[2]

Once the diagnosis is suspected, it is important to separate the child from the perpetrator. This is both diagnostic and therapeutic. The child should be placed in a different setting, with a separate caregiver, while the perpetrator receives appropriate psychiatric treatment as early as possible. A multidisciplinary team, including psychiatry, pediatrics, and child protection groups, is instrumental in further assessing the situation. Where appropriate, the child may require psychological support as well.

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