

Munchausen syndrome presenting as major trauma

S J Meek, J Kendall, P Cornelius, P A Younge

Abstract

The case is described of a man who feigned being struck by a vehicle, leading to an unnecessary major trauma response by the ambulance service and hospital. Suspicion that the patient suffered from Munchausen syndrome was confirmed by later investigation. Accident and emergency staff should file details of such patients on the department computer records system, where available, so that staff are alerted automatically to their presence, and share this information with neighbouring hospitals. All such patients should be treated according to ATLS guidelines until injury is ruled out, as for any other patient.

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Key terms: Munchausen syndrome; simulated major trauma

Since Asher described the Munchausen syndrome in 1951,¹ various ways in which such patients can present to accident and emergency (A&E) departments have been described. However, this case presented in a manner not previously described.

Case report

At 3 am the A&E department received prior warning of the imminent arrival of an unconscious male with chest injuries, who had been hit by a car.

His colleagues heard him cry out as a car passed them while they were working in a motorway contraflow, and they turned to see him lying face down. He complained of pain in the neck and inability to feel his legs. He appeared to lose consciousness in the ambulance.

On arrival in the A&E department, primary survey revealed a patent airway, an immobilised cervical spine, normal spontaneous breathing, and stable haemodynamics. He was receiving oxygen and had two large bore intravenous cannulae inserted in his arms. Blood samples were sent for group and base-line analysis.

His Glasgow coma scale was 5 on admission (no speech, no motor response, and eye opening to speech), and pupils were equal and reactive. He was noted to smell of alcohol. No visible external injury was apparent. Radiographs of the lateral cervical spine, chest and pelvis were normal.

After 25 minutes in the department, it became apparent that his level of conscious-

ness was improving: he started to mumble repeatedly "car's coming, car's coming" and "the lights, the cars". Although apparently having no motor function in his limbs, involuntary protective reflexes could be elicited (for example, dropping his hand towards his face).

Radiographs of skull, thoracic spine and left humerus were requested because of apparent tenderness in these areas, but no objective signs of injury were found and the radiographs were normal.

Spine immobilisation was removed and we confronted him with our strong suspicion that he was feigning injury. He was now fully oriented, but claimed he could remember only the lights and the cars. He asked to discharge himself and left walking slowly and deliberately with his girlfriend.

Discussion

Criteria for the diagnosis of Munchausen syndrome were established by Ireland² in 1967 (table). The diagnosis in our patient was confirmed by reviewing his casenotes from all four acute hospitals in the Bristol and Weston area: we found he fulfilled all Ireland's diagnostic criteria. The records revealed 23 previous admissions in the preceding eight years, virtually all for spurious reasons. Most interestingly, nine months previously he was admitted after being found lying in the road unable to move, claiming to have been run over twice by the same truck, and feigned paralysis of both legs, with a C5 sensory level.

Frequent outrageous lies were recorded (for example, he claimed to be on the waiting list for coronary artery bypass grafting at Papworth Hospital), and aggressive behaviour and self discharge were common. There was no obvious secondary gain in any of his admissions.

The importance of this case is that it shows a new way in which patients with Munchausen syndrome may present to A&E departments. Although trauma is a recognised but uncommon presentation of Munchausen syndrome,³ our patient even fooled his work colleagues into acting unwittingly as witnesses, and caused the police to waste time searching for a fictitious red Peugeot.

Ireland's criteria for Munchausen syndrome

- 1 Fictitious illness of a dramatic nature
- 2 Fictitious evidence of disease
- 3 Evidence of multiple previous medical procedures
- 4 Pathological lying
- 5 Aggressive behaviour
- 6 Discharge against medical advice
- 7 Multiple hospital admissions with "travelling"
- 8 Absence of any obvious secondary gain

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Feigning major trauma leads to a time consuming and expensive response from the ambulance service and receiving hospital, and therefore it is vital that any such patients are identified and confronted to deter further similar episodes. In some patients, psychiatric referral may be useful. Our patient has not been seen here or elsewhere in the area for the seven months since he was confronted.

It cannot be emphasised too strongly, however, that the same care must be taken to rule out injury in suspected Munchausen syndrome cases as for any other patient, using ATLS guidelines, before confrontation. There are times when injury cannot be ruled out in such patients – for example to the cervical spine, if the patient persistently complains of pain and tenderness over the vertebrae – and such patients must be admitted for further investigation.

The current standard system for identification of these patients is a handwritten “black book”, consulted by staff once suspicions are aroused. We would recommend that all computerised A&E departments transfer these manual “hospital hopper” records onto computer so that staff are alerted automatically when such patients register. For previously unknown cases, it is essential that staff take the trouble to investigate and inform other hospitals in the area of their findings. Has the time come for a national register of patients with Munchausen syndrome?

- 1 Asher R. Munchausen's Syndrome. *Lancet* 1951;i:339-43.
- 2 Ireland P, Sapira JD, Templeton B. Munchausen's syndrome: a review and a report of an additional case. *Am J Med* 1967;43:579-82.
- 3 Banerjee AK. Trauma and Munchausen's syndrome. *Arch Emerg Med* 1991;8:217-8.

Hair thread tourniquet syndrome

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Abstract

Tourniquet of hair and thread fibres may become tightly wrapped around a child's digit. The resultant ischaemia may lead to tissue necrosis and autoamputation. Experience with two patients is reported. The need for prompt recognition and complete removal of all fibres is stressed. The possibility of non-accidental injury should be born in mind.

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Key terms: digit; hair thread tourniquet syndrome

Case reports

CASE 1

An 18 month old girl was referred to us with mild fever and swelling and redness in the left fourth toe (fig 1). She initially presented to the accident and emergency (A&E) department one month previously when a ring of hair was removed from the toe and the wound dressed. Further pieces of hair were removed by the general practitioner in the ensuing weeks.

Examination revealed a tight hair tourniquet proximal to the distal interphalangeal joint, with marked distal venous congestion. A knotted hair loop was removed surgically (figs 2



Figure 1 Constricting ring around the left fourth toe producing distal swelling and discolouration. There is no external sign of the causative hair.



Figure 2 Following the removal of the hair, a tight constricting fibrosis remains.

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