

## A visitor with Munchausen's syndrome

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**ABSTRACT** – The arrival on the hospital ward of a person who was fabricating an illness was an unsettling experience for the medical and nursing staff involved. As the patient was expected only to be present for a short time and claimed to have a proven diagnosis, the approach may have been less rigorous than usual. The article describes the experience of three members of staff with a patient who proved to have Munchausen's syndrome, and their reaction to discovering the truth.

**KEY WORDS:** fictitious illness, Munchausen's syndrome

*Dr Crawford writes:*

Recently a patient was admitted to our oncology ward as an emergency. After he had spent four nights in the hospital I found myself asking him to leave.

Munchausen's syndrome has fascinated me ever since I read Richard Asher's original report<sup>1</sup> and the account by Pallis and Bandjee in the *BMJ*, 'McIlroy was here. Or was he?'.<sup>2</sup> Actually to encounter a person with Munchausen's syndrome is a most unsettling experience.

A man who gave his age as 33 attended the hospital complaining of severe pain, nausea and vomiting. According to the history he gave, he had HIV-related Kaposi's sarcoma and had recently had chemotherapy with doxorubicin and radiotherapy in a London teaching hospital. He mentioned in passing that his consultant oncologist had just gone away on holiday. He was taking slow release morphine sulphate tablets 50 mg bd. He claimed he was visiting his parents who lived in our locality.

The specialist registrar covering acute medicine on that day admitted him and discussed him with me and I saw him on my routine ward round on the Sunday morning. On his arrival on the admissions ward he had received a couple of doses of morphine subcutaneously, and we adjusted this to oral morphine given four hourly and discussed the principles of dose titration with him. He received metoclopramide and then cyclizine as anti-emetics. He complained that the pain was only slightly relieved by the analgesics that we were using, so we increased the dose of morphine. He was also written up for the anti-retroviral drugs he said he was taking regularly,

although he was reluctant actually to take the dispensed doses. Increasing demands for analgesia and persisting nausea which eventually led to a subcutaneous infusion of levomepromazine. By then our suspicions had been aroused, and were increased by his full head of hair, although his claim about chemotherapy was that he had had one dose of doxorubicin in the recent past. There was also a lack of skin lesions but he said that he had lesions in his pharynx.

Because he was a visitor from 200 miles away and we were not expecting to play a role in his definitive care, the approach to investigation was minimal. Each day that we saw him, we anticipated that we would attain adequate symptom control within 24 hours.

The nursing staff became increasingly concerned about the patient whom they regarded as peculiar.

There was a clear need to investigate this man's claims in more detail. A telephone call to the practice with which he claimed he was registered led to a conversation with the practice manager who could identify no patient of that name or that address. However, she had just received information about a patient admitted to a hospital in a neighbouring county some days before our visitor arrived here. He had given a similar address and date of birth but a different name. Provided with these details, I contacted the hospital concerned and compared the two attendances with a colleague there. The story of HIV-related Kaposi's sarcoma and of visiting parents in the locality was exactly the same. Perhaps the difference was that in the other hospital no opiates had been administered; the oral morphine was offered 'PRN' (as needed) but had not been taken up and he left after one night.

This knowledge enabled me to confront him and to ask him to move on. When he left the ward the staff found some packets of anti-retroviral drugs, issued in the same name that he had used in the other hospital but dispensed from the pharmacy of a third hospital.

As the physician responsible for this patient, I felt disappointed in myself. I had acceded to this man's desires for opiate analgesia, but in good faith believing that he was in severe pain. I had given such treatment in the absence of evidence for a diagnosis, but I had done so because I felt I was only providing short-term support; the definitive care was properly in the hands of others. I should have been more alert

to the lack of skin lesions and to the lack of alopecia, but the history seemed to account for this. On his departure this man gave the name and address of a general practitioner in another region and the name of his psychiatrist. Telephone calls subsequently revealed that these may be genuine, so my conscience about simply asking this man to be removed from the premises was relieved by the fact that something was in hand to help him.

All in all, finding that someone on your ward is an example of Munchausen's syndrome and is drawing inappropriately on limited resources of the service is most unsettling. I now have even more sympathy for those songbirds who find that they are feeding a cuckoo in the nest.

***Dr Jeyasanger writes:***

I reviewed this patient daily when he was on the ward. During my routine ward round, whenever I tried to speak with him, he cut the conversation short very abruptly and avoided eye contact. I thought that his behaviour was due to depression. Most of the time he was rude to me and to the nursing staff, demanding more analgesia and anti-emetics. Once I told him that it would be better if he were under the care of his original hospital and that I could arrange for the transfer as soon as possible. He immediately said no, since he had come for a holiday with his family and friends, and he stopped the conversation immediately.

***Sister Wright writes:***

This patient was treated at face value by the nursing staff. His history was plausible and we do not disbelieve patients at first meetings. Initially the nurses spent a great deal of time with him, reassuring him and offering support and sympathy, as was appropriate.

As time went on, his behaviour changed and he became increasingly agitated when asked to try alternative medication routes. The nurses felt that he was attention-seeking and that his behaviour was like that of a drug addict, constantly demanding further treatments. He was verbally aggressive to the nursing staff and he self-harmed by banging his head on the nursing station in front of the staff. This intimidated the nurses and Security had to be called to support them.

The nurses began to question his behaviour and in their opinion he was peculiar, or colloquially 'not quite a full shilling'. This then led the staff to question his history and his assertion that he was on holiday seeing his parents who lived locally. No staff member could recall his parents actually visiting him. His nursing documentation was reviewed and there was no address for his parents. When Dr Crawford gained confirmation that this patient had deceived all of us, the nurses felt cheated at the time spent with this patient. They were concerned that other patients had been unnecessarily disturbed by his behaviour and had been denied nursing time and support.

We also felt that we had been duped and that, as professionals, we should have realised earlier. It was the first time any of the nursing staff had had direct contact with a patient with Munchausen's syndrome.

## References

- 1 Asher R. Munchausen's syndrome. *Lancet* 1951;i:339-41.
- 2 Pallis CA. Bandjee AN. McIlroy was here. Or was he? *BMJ* 1979;i: 973-5.