

Munchausen syndrome by proxy presenting as hearing loss

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Abstract

Objective: To review the diagnosis of Munchausen syndrome by proxy, a factitious disorder, in which symptoms are induced or feigned, usually in a child, by the caregiver. The involved caregiver seeks to gain attention or sympathy and often has a psychological need to maintain the sick role. We highlight the diagnostic difficulties and factors that may help with diagnosis in an otolaryngology setting.

Method: We present the case of Munchausen syndrome by proxy presenting with hearing loss in a five-year old boy, who was diagnosed eight years after his initial presentation. A literature review of Munchausen syndrome by proxy cases presenting with ENT symptoms is provided.

Conclusion: Munchausen syndrome by proxy is a diagnosis that otolaryngologists should be aware of, particularly where recurrent or persistent illnesses in children, especially those involving otological symptoms, are refractory to the usual treatments.

Key words: Factitious Disorders; Munchausen Syndrome; Munchausen Syndrome By Proxy; Hearing Loss; Child; Diagnosis

Introduction

Munchausen syndrome by proxy is the production or feigning of symptoms in another person, usually a child, for which the carer seeks medical diagnosis and treatment. Mild symptoms of an existing disorder may also be deliberately worsened or exaggerated.

Unlike with other factitious disorders (such as malingering), where there may be a financial benefit, there is no secondary gain in Munchausen syndrome by proxy. The involved caregiver seeks to gain attention or sympathy and often has a psychological need to maintain the sick role. The vast majority of cases are in mothers, many of whom have experience of working in healthcare. Commonly reported symptoms include bleeding, seizures, apnoea, diarrhoea, vomiting, fever and rash. We report a case of Munchausen syndrome by proxy presenting with hearing loss.

Case report

A five-year-old boy, who was being investigated for a potential diagnosis of attention deficit hyperactivity disorder, was referred by his general practitioner to the ENT clinic because his mother was concerned about his hearing.

An initial pure tone audiogram showed a moderate conductive hearing loss in the right ear and normal hearing in the left. A clinical examination revealed both tympanic membranes to be dull and tympanograms were type B bilaterally. A diagnosis of otitis media with effusion was made and conservative management was begun.

At a further review, the patient's mother reported that her son was struggling at school and a repeat audiogram showed persistent right-sided mild conductive hearing loss. He underwent bilateral grommet insertion after which an audiological assessment showed that his hearing had normalised.

His hearing remained normal until after grommet extrusion 10 months later. He then developed bilateral mild conductive hearing loss confirmed by pure tone audiometry and was referred for bilateral hearing aids.

At follow up eight months later, the mother reported that her son's hearing had worsened, although pure tone audiometry showed it to have normalised. Otoscopy revealed a mild retraction of the right tympanic membrane and a type B tympanogram on that side, with normal findings and tympanogram on the contralateral side. The mother was keen for her son to continue with hearing amplification.

At follow up one year later, pure tone audiometry was again found to be entirely normal, and it was decided that the patient no longer needed hearing aids. The patient's mother was unhappy about this because she felt that he was struggling with his hearing. After another annual follow up with normal findings, the patient was discharged.

Three months later, the patient was again referred to the ENT clinic by his general practitioner because of maternal concerns regarding his hearing. On review, although the patient reported he was unable to hear when sat at the back of class in school, clinical examination, audiometry and tympanometry were all found to be normal.

A further review was arranged at the mother's request, and again the findings were normal. The patient and his mother

stated that they wanted him to have hearing aids again. This was declined on the basis of normal findings, and the patient's mother requested a further consultation during the winter months.

At this review, the patient's hearing was again found to be normal, but the mother now reported that the patient had had three episodes of tonsillitis within five months. This was felt to be borderline for tonsillectomy, which prompted a further consultation.

When the patient attended the following consultation with his father, into whose custody he had now been taken, it became apparent the child had been coached by his mother to score poorly on hearing tests. A diagnosis of Munchausen syndrome by proxy was made at this point, eight years after the child's first contact with the ENT department.

Discussion

Munchausen syndrome was first described by Asher in 1951¹ and Munchausen syndrome by proxy was first described by Meadow in 1977.² The conditions are named after Baron von Munchausen, who was an eighteenth century German officer who was known for telling exaggerated stories about his adventurous travels. Munchausen syndrome by proxy is more common in mothers, whereas Munchausen syndrome is more common in males.³

Munchausen syndrome was originally subclassified into abdominal, haemorrhagic and neurological types. Otolaryngological manifestations most commonly involve facial pain or swelling, or otological symptoms.^{4,5} In Munchausen syndrome by proxy, more than 80 per cent of cases presenting to the ENT clinic have otological symptoms, predominantly involving the external auditory canal, such as recurrent otitis externa.⁴

Our literature search identified seven cases of Munchausen syndrome by proxy presenting with ENT symptoms,^{6–11} with six of these involving children (Table I). Five of the cases involved otological presentations; most commonly either recurrent otorrhoea or otitis externa.^{6–8,10} One case of Munchausen syndrome by proxy presented with sensorineural hearing loss in an infant.⁸ In this case, the infant had somewhat delayed development in auditory response behaviour. The mother therefore obtained hearing aids for the child despite repeatedly normal auditory brainstem response testing (ABR). As in our case, the mother expressed ongoing concerns regarding the child's hearing despite normal investigations, which prompted the diagnosis.

Munchausen syndrome by proxy is characterised by repeated parental efforts to secure attention for their child's illness, usually in multiple medical settings. Results obtained in previous evaluations that are normal or contradict the parent's opinions are discounted or misinterpreted. There is a tendency for the child to collude with their parents, as demonstrated in our case, in which the child reported poor hearing in class and on occasions deliberately scored poorly on pure tone audiometry.

Munchausen syndrome by proxy cases may present with the parent being an 'active inducer' through direct efforts to induce dramatic symptoms and signs of illness. This type usually involves younger children, and the involved mother usually seems very pleasant and helpful. The more common type is the 'doctor addict', as in our case, where the parental efforts are more passive and symptoms less extreme, involving false reporting of medical history. The children in these cases tend to be older and the mother more commonly has an angry, distrustful attitude towards the clinician. The overriding factor in all cases is a rigid parental belief in the child's illness.¹²

TABLE I
REPORTED CASES OF MUNCHAUSEN SYNDROME BY PROXY PRESENTING WITH ENT SYMPTOMS

| Source | Presentation | Active inducement by caregiver | Time from presentation to diagnosis | Additional clinical details |
|---------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bourchier ⁶ 1983 | 2-year-old male. Recurrent otorrhoea | Mother introduced blood into child's ears | 2 years | Poor weight gain, haematemesis, malaena, cough and unsteady gait |
| Zohar <i>et al.</i> ⁷ 1987 | 5-year-old male. Chronic bilateral otitis externa | Mother inflicted ear canal lesions | 2 years | – |
| Zohar <i>et al.</i> ⁷ 1987 | 5-year old male. Recurrent otitis externa | Father introduced chalk into child's ears | Not stated | Father had a history of Munchausen syndrome |
| Kahn <i>et al.</i> ⁸ 1991 | 11-month-old female. Sensorineural hearing loss | – | 1 year | Diagnosed with pseudobulbar palsy, cortical blindness and developmental delay. None of these were apparent at time of MSBP diagnosis. Underwent apparently unnecessary gastrointestinal surgery and insertion of a gastrostomy feeding tube |
| Magnay <i>et al.</i> ⁹ 1994 | 7-month-old female. Excoriated lesions around nostrils | Mother pinched and scratched child to inflict lesions | 3 months | Excoriated perianal lesions, diarrhoea, bloody stools, foot ulcers and failure to thrive |
| DiBiase <i>et al.</i> ¹⁰ 1996 | 3-year-old male. Chronic left-sided otorrhoea | Mother injected faecal fluid into child's central line during hospitalisation | Not stated | – |
| Somani <i>et al.</i> ¹¹ 1998 | 28-year-old male. Burning sensation over left cheek and ear | – | 10 days | Acid poured over patient by wife at night |

MSBP = Munchausen syndrome by proxy

It is thought that making the child's illness a focal point of family life allows the parents to deal with their own psychological difficulties, which commonly involve marital problems. Typically, the mother appears very concerned and perceives the child to be extremely vulnerable. The father often has limited involvement and, as in our case, rarely attends medical appointments. In some cases where a mild condition is present, with the symptoms being exaggerated, the father may actively or passively provide support through embellishment of the medical history.¹³

- **Munchausen syndrome by proxy is the production or feigning of symptoms, usually in a child, for which the carer seeks medical treatment**
- **Cases may present to otolaryngologists, with otological symptoms in 80 per cent**
- **It is a form of child abuse, and healthcare workers must inform child protection agencies**
- **Otolaryngologists should remain vigilant for this syndrome, particularly when recurrent or persistent illnesses in children are refractory to treatment**

A diagnosis of Munchausen syndrome by proxy can be difficult to make, particularly given our reliance on parental reporting in paediatric cases. This is made even more difficult if feigned symptoms overlap with or exaggerate existing or previously experienced symptoms. In our case, there was clear clinical evidence of otitis media with effusion at the outset, which was treated appropriately. The ongoing parental concern despite normal clinical findings and normal audiometry and tympanometry caused the follow up to continue for longer than would otherwise have been necessary. The child also had hearing aids fitted when these were probably not necessary, which further promoted the illness-maintaining behaviour.

In addition, objective measures of hearing do not corroborate a history of poor hearing from the child and parent for a central auditory processing disorder. Children with this disorder have difficulty discriminating speech sounds and frequently misinterpret what is said, particularly when there is background noise, yet have normal age-appropriate hearing tests. Speech audiometry (in older children) and ABR are useful for differentiating these children from Munchausen syndrome by proxy cases.

Other signs that should cause concern include an inconsistent medical history out of keeping with clinical signs and parental behaviour, including multiple attendances at other hospitals, a readiness for intervention and a reluctance to provide details of previous healthcare providers. The diagnosis should be suspected in children with recurrent or persistent illnesses that are refractory to treatment.

Where a diagnosis of Munchausen syndrome by proxy is suspected, it is important to corroborate the medical history given by the parent by obtaining records from other hospitals at which the patient has been treated.

Munchausen syndrome by proxy is classified as a form of child abuse and healthcare workers therefore have a duty to contact child protection agencies. It has been suggested that the caregiver should be 'blacklisted' at hospitals where

they have attended to alert medical staff and avoid potential over-treatment.⁴ Some authors suggest that in suspected cases of illness exaggeration, in-patient admission may be useful to directly observe illness characteristics and therefore identify cases of exaggeration.¹³ This may, however, also serve to reinforce sick role behaviour.

Conclusion

Munchausen syndrome by proxy cases may present to otolaryngologists, and 80 per cent of these will do so with otological symptoms.⁴ It is therefore a diagnosis that otolaryngologists should be aware of, particularly where recurrent or persistent illnesses in children are refractory to the usual treatments. It is important that otolaryngologists, as well as allied specialists such as audiologists and speech and language therapists, have an awareness of Munchausen syndrome and Munchausen syndrome by proxy, primarily to prevent potential harm to patients and over-treatment, but also to prevent wasting limited healthcare resources.

Acknowledgement

We thank Teresa Loxley, an audiologist at Sheffield Children's Hospital, for providing access to audiograms and clinical notes.

References

- 1 Asher R. Munchausen's syndrome. *Lancet* 1951;**1**:339–41
- 2 Meadow R. Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet* 1977;**2**:343–5
- 3 Taylor S, Hyler SE. Update on factitious disorders. *Int J Psychiatry Med* 1993;**23**:81–94
- 4 Alicandri-Ciuffelli M, Moretti V, Ruberto M, Monzani D, Chiarini L, Presutti L. Otolaryngology fantastica: the ear, nose, and throat manifestations of Munchausen's syndrome. *Laryngoscope* 2012;**122**:51–7
- 5 Cohen NL, Breda SD, Lebowitz AS. Otogenic Munchausen syndrome. *Am J Otol* 1990;**11**:192–5
- 6 Bouchier D. Bleeding ears: case report of Munchausen syndrome by proxy. *Aust Paediatr J* 1983;**19**:256–7
- 7 Zohar Y, Avidan G, Shvili Y, Laurian N. Otolaryngologic cases of Munchausen's syndrome. *Laryngoscope* 1987;**97**:201–3
- 8 Kahn G, Goldman E. Munchausen Syndrome by Proxy: Mother Fabricates Infant's Hearing Impairment. *J Speech Hear Res* 1991;**34**:957–9
- 9 Magnay AR, Debelle G, Proops DW, Booth IW. Munchausen syndrome by proxy unmasked by nasal signs. *J Laryngol Otol* 1994;**108**:336–8
- 10 DiBiase P, Timmis H, Bonilla JA, Szeremeta W, Post JC. Munchausen syndrome by proxy complicating ear surgery. *Arch Otolaryngol Head Neck Surg* 1996;**122**:1377–80
- 11 Somani VK. Witchcraft's syndrome: Munchausen's syndrome by proxy. *Int J Dermatol* 1998;**37**:229–30
- 12 Libow JA, Schreier HA. Three forms of factitious illness in children: when is it Munchausen syndrome by proxy? *Am J Orthopsychiatry* 1986;**56**:602–11
- 13 Masterson J, Dunworth R, Williams N. Extreme illness exaggeration in pediatric patients: A variant of Munchausen's by proxy? *Am J Orthopsychiatry* 1988;**58**:188–95

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Ms N Ashraf takes responsibility for the integrity of the content of the paper

Competing interests: None declared