

be admitted for assessment (Enoch & Trethowan, 1979; Carney *et al*, 1987) and suggests the need for follow-up after apparent recovery. Further reports should help clarify the prognosis of this rare disorder.

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The Million Dollar Man Resource Implications for Chronic Munchausen's Syndrome

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Munchausen's syndrome in a man of subnormal intelligence is described. The case is unique for the extent of detailed, corroborated history. This man has been a voracious consumer of NHS and other services, and an estimate has been made of his cost to the health and prison services. The case raises various ethical, forensic, and resource issues.

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Munchausen's syndrome has been extensively described since Asher's (1951) original report of patients with "acute illness supported by a plausible and dramatic history . . . made up of falsehoods". Although he described somatic presentations (acute abdominal, haemorrhagic, and neurological), subsequent writers have reported psychological complaints. These include reaction to bereavement often accompanied by self-harm (Snowden *et al*, 1978), depression (Ben-Tovim, 1978), thought disorder (Cheng & Hummel, 1978), post-traumatic stress disorder (Geraciotti *et al*, 1987), and alcohol abuse (Caradoc-Davies, 1988). DSM-III-R (American Psychiatric Association, 1987) also refers to presentations with suicidal ideation, memory loss, hallucinations, and dissociative and conversion symptoms.

The following case illustrates many of these typical features. An additional point of interest is his verified

history of educational difficulty and subnormal intelligence. The case is unique, however, for the extent of corroborated, detailed biographical and medical history. Since the onset of his disorder he has been a voracious consumer of services.

Case report

The subject is an unemployed man in his 30s who lives in London. The authors have documentary evidence of 545 treatment episodes at 84 hospitals over 1977–88. As he provided an inaccurate history, information was obtained from his mother, and where direct family knowledge existed, social-service and probation reports.

He was born in the middle of a large sibship to an impoverished but stable working-class family. His father, who was often away from home due to his occupation, died prematurely of cancer during the subject's adolescence. His mother is alive and well. Although there is no psychiatric illness in the family, three siblings had educationally subnormal schooling and one has epilepsy. There is no reported history of discord or distorted relationships within the family.

His early development was complicated by threatened miscarriage at four months, a prolonged difficult labour, and at nine months, measles requiring hospital admission. He received schooling for educational delay from 7–16 years, at which time he had no friends and was often truant.

Also, he was noted to be untruthful, disobedient and engaged in petty theft. Employment has consisted of brief, unskilled manual work, his main source of income being begging. He indicated a heterosexual orientation, but there are no substantiated relationships. There have been inappropriate sexual advances to female relatives, patients, and staff. He is not dependent on alcohol or drugs, but has abused phenobarbitone and phenytoin. Confirmed medical history includes humerus and scaphoid fractures, asthma, and iron-deficiency anaemia.

He had convictions, as a juvenile, for hoax telephone calls to the fire brigade, and as an adult for handbag theft, and assaulting a nurse. Additionally he set fire to a prison cell from which he received severe burns, and is suspected of causing minor hospital fires. Allegedly, he also engages in petty thefts and frauds, such as collecting excess public transport fares. Psychiatric reports cite him as immature, of low intelligence, and psychopathic. He has been uncompliant with a community-service order and probation, including condition of treatment in a mental handicap hospital. Following criminal proceedings he was made subject to a section-60 hospital order, which proved ineffective in altering his behaviour. He responded best to 13 months of youth custody, when prison medical reports describe improvements in confidence, self-care, relationships, and work record.

The authors contacted 205 hospitals, 187 in the four Thames health regions and 18 other selected hospitals, of which 161 (79%) replied. During the 12 years 1977–88 he has spent over six years in institutions, comprising 1300 days in psychiatric units, 556 days in prison, and 354 days in medical care. He has had 284 casualty attendances and 261 hospital admissions, averaging 25 per year (corrected for time in prison), the length of stay varying from a few hours to 13 months (mean 6.3 days). He has often been detained under sections of the Mental Health Acts (62 times), particularly section 136 (48 times).

Presentations have varied, but predominantly concerned self-harm (305). These have included overdose (192) with drugs such as aspirin (89), phenobarbitone (49), and phenytoin (17). Drug intake has been detected on 28% of admissions, and although levels were never high enough to require treatment, he has received forced alkaline diuresis twice. Dangerous behaviour (85) has included running in traffic (56), threatening to jump from heights (17), and walking on railway tracks (12). He has presented with psychiatric disorders (69) including reaction to feigned bereavement (51) and 'hearing voices' (18). Most episodes of physical illness (156) were feigned or self-inflicted, for example, epilepsy (50), head injury (28), collapse (21), and asthma (8). However, organic pathology has been confirmed frequently (28).

Although he is the tenant of a council flat, it is bereft of furniture or personal effects. He spends his time seeking hospital admission, visiting unstructured day centres, travelling, living in reception centres or as a vagrant, and generates income by begging. His family feel unable to help him and only remain in contact through agencies attempting to establish the patient's identity.

He presents with evidence of poor self-care. He can be polite, cooperative, and plausible, but may be angry if

Table 1
Cost of care

Type of care	Unit cost: £	Units	Amount: £
Psychiatric ¹	150 per day	1300	195 000
Medical ¹			
teaching	1467 per episode	91	133 497
non-teaching	1124 per episode	78	87 672
accident and emergency	30 per attendance	284	8520
Prison ²			
youth custody	346 per week	57	19 722
remand	309 per week	21	6489
Total			450 900

1. Figures from Guy's Hospital Finance Department.
2. Home Office (1990).

challenged and has assaulted patients and staff. The personal history and antecedents to presentation contain gross distortions and fabrications. On occasion his history contains an ironic element of truth, such as giving his place of birth as Leicester, where he received nine months in-patient treatment. Occasionally he complains of hearing voices in the second person, not in external space, which have the form of pseudohallucinations. Cognitive examination is consistent with low intelligence. Physical examination reveals old injuries and pallor. His standard reply to the question of his motivation for seeking hospital admission is "It's a dangerous world out there, Doctor".

His haemoglobin level varies between 65 g/l and 153 g/l, with iron deficiency. Computerised brain tomography is unremarkable. Electroencephalography in December 1981 showed "episodic forms and slow waves over the left temporal area, possibly associated with brain damage" but was normal in February 1981, 1986 and 1988. He has a reading age of seven and IQ by Raven's matrices of 68.

The costs of his care are summarised in Table 1. Prison costs are derived from the *Report on the Work of the Prison Service* (Home Office, 1990). Hospital costs have been estimated using information supplied by Guy's Hospital. The sum of £450 900 does not include assessment under sections of the Mental Health Act, police, ambulance, social service, and legal costs. Neither has it been possible to estimate the cost of out-patient and primary health-care treatment including pharmaceutical expenses. Also hidden from this figure are costs such as those arising from interference with train services. In addition, this is certainly an underestimate because of his extreme mobility, his use of aliases, the inability of hospitals to access their records, and the restricted sample of hospitals approached. Moreover, his peregrinations continue.

Discussion

Despite controversy concerning diagnostic criteria (Rogers *et al*, 1989) there can be no doubt that this patient meets DSM-III-R criteria for factitious disorder with both physical and psychological symptoms. He also fulfils DSM-III-R criteria for antisocial personality disorder. However, this case

is more interesting for the expenditure consequent upon his behaviour, and thus raises ethical issues concerning his future management.

Solutions such as keeping blacklists (Birch, 1951), "exposing . . . cases" (Asher, 1951) and the use of a central register (Birch, 1951) are superficially attractive for their simplicity. The use of aliases and inadequate record keeping reduce the effectiveness of blacklists (including for research purposes) and may deny patients treatment for serious medical conditions. Since blacklists are only referred to after patient recognition, they perform mainly cathartic and punitive functions and fail to prevent unnecessary expenditure and intervention. Exposing cases (by publication of case histories) may be confused with confronting the patient in order to manipulate self-discharge. In addition, objections have been raised to these approaches on the basis that they breach physician-patient confidentiality. In the USA, where this issue has been more widely debated, the consensus is that disclosure should only occur where there is risk of serious physical harm (Kass, 1985). In the UK, a doctor who discloses information without patient consent may have to justify the decision to the General Medical Council. Disclosure to a central register or any other third party is qualitatively distinct from normal communication between doctors who are treating patients and acting in their interests.

The traditional approach has been to consider these individuals from the viewpoint of their psychopathology and disordered behaviour. There has been prolific speculation as to possible aetiology and motivation (e.g. Asher, 1951; Cremona-Barbaro, 1987) but without consensus. An alternative view is to regard these people as a parasitic manifestation of, and arising from, a dysfunctional system. The system is deficient at two levels. Firstly, hospitals are not consistently able to recognise such cases, as evidenced by the multiple sets of records and casualty notes within single health districts. Recognition usually leads to a discharge from care, which fails the patient and ultimately the system itself as it ensures further presentation (in this case often unrecognised at the same hospital). The system was also deficient in dealing with physical illness in that he was severely anaemic for three years and had multiple presentations for treatment of fractures.

These patients may be regarded as legally competent and therefore autonomous (Sadler, 1987). The implication of this is that they should be given choices and be held responsible for their actions. In practice this would mean that patients could not be treated without their consent, that they would be responsible for their treatment costs, and could

be convicted for fraudulent use of services and imprisoned. The contrary view holds that due to their disorder their behaviour is not volitional, they are unable to make appropriate choices about treatment and, like psychotic patients, require a paternalistic approach. It is the authors' view that this patient best fits the latter model. Under section 3 of the Mental Health Act 1983, such patients with 'psychopathic disorder' are liable to be detained for treatment if this would alleviate or prevent deterioration of their condition and it is necessary for the health of the patient or for the protection of others.

This patient has a chronic, severe, treatment-resistant condition. He belongs to a group of patients requiring long-term management including use of semi-secure facilities (Coid, 1991). Recent findings (Bhugra, 1988) that this disorder presents more commonly than is widely recognised should serve as a warning against neglect of the clinical and financial consequences.

Previously, the implications for district health authorities were not attractive. Until April 1991, financial incentives acted perversely by encouraging abdication of responsibility for patient care. Since then, financial responsibility rests with the patient's original health authority. A health authority faced with annual charges on the scale of this patient would be obliged to attempt treatment locally, fund private hospital specialist treatment, or combine resources with other districts.

The authors advocate tackling this problem at a number of different levels. In clinical practice, medical staff need to have an awareness of the condition in order to detect it early. Consultants must adopt a therapeutic approach if patients with this disorder are to receive treatment. Hospital managers and commissioning authorities need to accept financial responsibility. Treatment should be aimed at promoting social integration and reducing the inappropriate behaviour. The form of treatment must be considered speculative at this stage, but would include cognitive and behavioural techniques such as the teaching of coping skills, social-skills training, and education. For patients who are not prepared to cooperate with such treatments it is the authors' assertion that many of them would fall within the provision of the Mental Health Act. Thus, patients with Munchausen's syndrome would be afforded care equivalent to that offered in other psychiatric disorders. It has been strongly argued that a case register would prove financially ineffective and detrimental to patient care. A more appropriate use, analogous to the National Register of Drug Addicts, would be for its value in service planning and research (Davey, 1991). Unless such a policy is widely introduced it will

continue to be the case that never in the field of medical endeavour has so much been spent by so many for so few to such little effect.

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Wilson's Disease and Catatonia

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A 12-year-old Indian boy presented to a psychiatric unit with catatonia. He was subsequently diagnosed to have Wilson's disease. Symptoms improved on treatment with penicillamine, zinc sulphate, and benzodiazepines.
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In 1874 Karl Ludwig Kahlbaum described the syndrome of catatonia in a small monograph. He stressed that catatonia is strongly associated with both depression and mania. He also gave examples of catatonia associated with organic illnesses. In 1893 Emil Kraepelin incorporated catatonia as a subtype of dementia praecox, later termed schizophrenia by Eugene Bleuler. Subsequently, there has been a tendency to regard catatonia as a purely psychiatric condition, commonly associated with schizophrenia (Barnes *et al*, 1986). However, the catatonic syndrome can occur with cerebral processes other than the psychoses.

Gelenburg (1976) defined catatonia as composed of motor signs, psychosocial withdrawal, and bizarre repetitive behaviour, and recommended that it be considered a syndrome with various possible causes in addition to depression and schizophrenia. He listed a large number of organic conditions associated with the catatonic syndrome. These include cerebral tumours, epilepsy, infections, metabolic causes, cerebral trauma, and drugs and toxins.

Fisher (1989) concluded that in most of the cases considered by Gelenburg to be associated with catatonia, the catatonia had not been diagnosed according to strict criteria. In many case reports the diagnosis of catatonia was only a tentative label applied by a referring agency. There is a lack of a clear definition as to what exactly constitutes catatonia, and descriptions of the motor phenomenon are often inadequate.

Gelenburg's original list of organic conditions associated with the catatonic syndrome does not