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Clinical Records

Munchausen syndrome by proxy unmasked by nasal signs

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Abstract
The protean manifestations of child abuse continue to cause diagnostic difficulty. Recent observations of the high mortality in victims of Munchausen syndrome by proxy, and their siblings, reinforce the need for early diagnosis and appropriate intervention. We report the nasal manifestations which unmasked Munchausen syndrome by proxy in an infant who presented with intestinal and peri-orifical signs masquerading as Crohn's disease. The possibility of Munchausen syndrome by proxy should be considered in an infant with persistent nasal excoriation presenting as part of an undiagnosed illness.

Key words: Munchausen syndrome by proxy; Child abuse; Otolaryngology; Gastroenterology

Introduction

Following the description of the battered-child syndrome as a clinical entity (Kempe *et al.*, 1962), further definition of the breadth of child abuse has identified a specific pattern of abuse known as Munchausen syndrome by proxy (MSBP) (Meadow, 1977). In MSBP, the child's carer, usually the mother, fabricates illness in the child, either by inducing physical signs of illness or by deliberately misleading the physician into believing the child is ill. Meadow (1982) points out that the victims of MSBP are usually aged less than six years, after which they would be likely to reveal the deception. However, as well, as causing needless and often harmful investigation, MSBP has a mortality of nine per cent (Rosenberg, 1987). At least eight per cent of survivors suffer severe physical long-term morbidity. Many more suffer long-term psychological morbidity (McGuire and Feldman, 1989). Especially alarming is the observation that siblings of victims of MSBP have an extremely high mortality (Bools *et al.*, 1992): 11 per cent died in early childhood, the cause of death not being identified.

There are few reports of child abuse presenting with signs in the head and neck (Manning *et al.*, 1990). Nevertheless, otolaryngologists may be asked to see children with unusual symptoms affecting the aural and nasal orifices in whom the diagnosis of MSBP should be considered.

Case report

The Child

A seven-month-old baby girl was referred to a tertiary referral centre for colonoscopy and investigation of a three-month history of unexplained screaming episodes, diarrhoea, bloody stools, failure to thrive, and the recent appearance of nasal and cutaneous lesions. Before transfer, she had been investigated at two hospitals; received two general anaesthetics; undergone gastroduodenoscopy, a laparotomy, and insertion of central venous catheter with subsequent infection; had been commenced on morphine infusion for pain control, received nil by mouth, and was intravenously fed.

On arrival there was a fresh, completely circumferential excoriation on the inner aspect of each nostril, with sparing of the tip of the nose. There was also a clearly demarcated, full-thickness, denuded, weeping and bleeding lesion around the anus, some excoriated, eczematous, lesions around the ankle, and some demarcated deep ulcers on the soles of each foot. Observation charts recorded frequent, watery, blood-stained stools. Episodes of screaming were prolonged and impressive.

The possibility of Crohn's disease with peri-orificial manifestations was considered, although the extraintestinal features were not typical. However, gastroduodenoscopy and colonoscopy were normal. C-reactive protein was not elevated, and serum zinc level was normal. Moreover, the nasal lesions appeared traumatic, not part of a multisystem granulomatous disorder.

Her mother explained that the skin lesions were self-inflicted, caused by rubbing the sheets or scratching her feet and ankles with sharp toenails. The nasal lesions (Figure 1 a–d) were allegedly caused by the child rubbing the nose against the sheets, exacerbated by scabs sticking to the bedding. The explanation for the traumatized nares was inconsistent with the findings, and implausable. There was no explanation offered for the perianal lesion.

The discrepancy between nasal signs and history raised the possibility of MSBP. Vigilant one-to-one nursing was implemented. When stools were collected and inspected by medical staff, there was no evidence of bloody diarrhoea. However, the nasal problem progressed to partial nasal obstruction caused by scabbing (Figure 1 b). All episodes of bleeding or recrudescence of cutaneous lesions occurred when the mother was alone in the room, in spite of extreme nursing vigilance. The explanations were implausable. During one episode of prolonged screaming,

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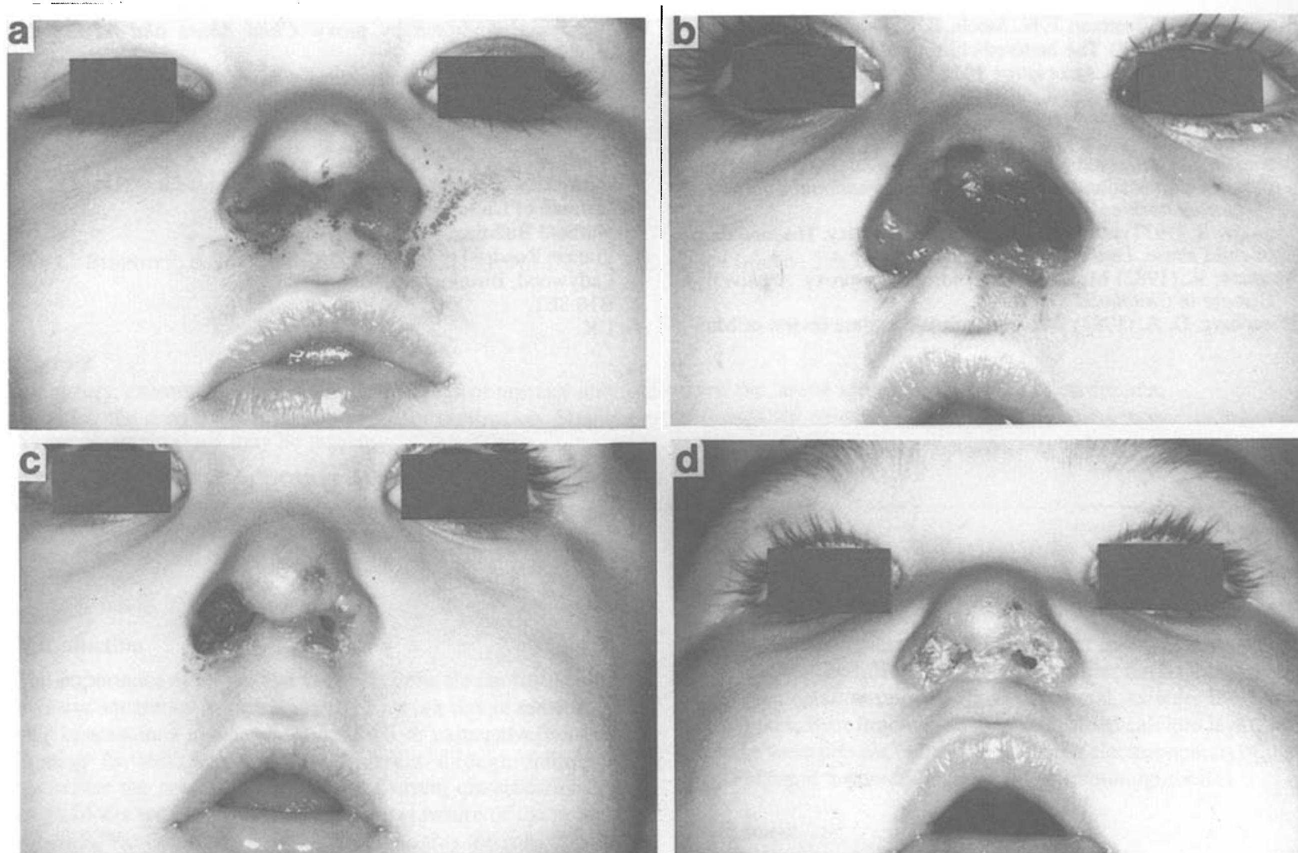

FIG. 1

Nasal excoriations on the inner aspect of the nares, with sparing of the tip of the nose: (a and b) before separating the mother from her child; (c) 1 day after separation; (d) 3 days after separation.

the mother was witnessed with her hand beneath the infant's blanket, pinching the raw perineum.

After confronting her with our observations and explaining our suspicions, the mother was excluded from contact with her child. Over the next three days, dramatic healing of all lesions occurred (Figure 1 c and d). Marked weight gain was immediate, screaming stopped, and there has been no further bleeding or diarrhoea.

The Mother

The mother, aged 21 years, a married trainee psychiatric nurse, spent all her time with her infant. There had been no previous concern by primary health professionals over the care of the child. The father, aged 33 years, a semi-skilled manual worker, rarely visited the hospital owing to work commitments.

After initial denial, the mother admitted to inducing all the cutaneous symptoms by systematically picking, scratching and pinching; inducing diarrhoea by administration of neat black-currant cordial; misappropriating pathological specimens; and altering infusion rates of intravenous feeds. She was unable to explain why she harmed her daughter.

Her past history revealed that she herself had suffered from Munchausen syndrome, and had been admitted to an adolescent psychiatric unit when fabricating epilepsy. Later she disclosed a harrowing personal history with allegations of child sexual abuse by her father and a paedophile ring.

Outcome

The child is healthy and thriving with foster parents, under a Care Order implemented through Child Protection Proceedings. The parents have separated, and the mother has gone to live in a caring religious community overseas.

Discussion

The incidence of Munchausen syndrome by proxy is not known, but is diagnosed with increasing frequency owing to increased awareness. Symptoms of bleeding from ears (Bourchier, 1983; White, 1985) and epistaxis (Meadow, 1977) have been described as part of multiple symptoms in individual victims of MSBP, representing the presenting features in probably less than three per cent of cases (Rosenberg, 1987). The reasons why the perpetrator engages in the harmful behaviour is not understood. However, as our report illustrates, the background to such cases may be extremely complex. We have much to understand about the psychological issues underlying the deviant behaviour seen in this condition. Furthermore, the behaviour frequently persists after diagnosis and confrontation. In order to ensure the safety and normal development of the child and any siblings, if they remain with the family, professional involvement will usually be necessary until they are adult, usually on a statutory basis (Bools *et al.*, 1992). Diagnosis of Munchausen syndrome by proxy is not feasible without first considering the possibility.

References

Bools, C. N., Neale, B. A., Meadow, S. R. (1992) Co-morbidity associated with fabricated illness (Munchausen syndrome by proxy). *Archives of Disease in Childhood* **67:** 77–79.

Bourchier, D. (1983) Bleeding ears: case report of Munchausen syndrome by proxy. *Australian Paediatric Journal* **19:** 256–257.

https://doi.org/10.1017/S0022215100126696 Published online by Cambridge University Press

Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemuller, W., Silver, H. K. (1962) The battered-child syndrome. *Journal of the American Medical Association* **181:** 17–24.

McGuire, T. L., Feldman, K. W. (1989) Psychological morbidity of children subjected to Munchausen syndrome by proxy. *Pediatrics* **83:** 289–292.

Manning, S. C., Casselbrant, M., Lammers, D. (1990) Otolaryngologic manifestations of child abuse. *International Journal of Pediatric Otorhinolaryngology* **20:** 7–16.

Meadow, R. (1977) Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet* **ii:** 343–345.

Meadow, R. (1982) Munchausen syndrome by proxy. *Archives of Disease in Childhood* **57:** 92–98.

Rosenberg, D. A. (1987) Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse and Neglect* **11:** 547–563.

White, S. T. (1985) Surreptitious warfarin ingestion. *Child Abuse and Neglect* **9:** 349–352.

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