

# Spitting in the ear: a falsified disease using video evidence

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## Abstract

We present the case of Munchausen's syndrome by proxy (MSBP) in which the mother spat and placed blood in her child's ear, and videoed the result, in order to gain the attentions of the medical profession. This is the first case report of this kind and may represent a disturbing trend in the use of digital photography and video to support factitious illnesses.

**Key words:** Factitious Disorders; Ear; External; Otitis Media

## Introduction

Munchausen's syndrome is a falsified physical or mental illness created in order to obtain medical intervention. This condition, now commonly known as a factitious illness, was first described in three case reports by Asher in 1951.<sup>1</sup>

It is named after Baron K F H von Munchausen, a raconteur of extraordinary tales about his life as a soldier, hunter and sportsman who served with the Russian army against the Turks in 1760. He became famous as the hero of fairy tales written by Rudolf Erich Raspe in 1784.

More recently, in 1977, Meadow described a form of this disease where the parents were responsible for fabricating the disease in order to subject their children to unnecessary medical intervention.<sup>2</sup> This is known as Munchausen's syndrome by proxy (MSBP), Meadow's or Polle syndrome. This is a specific form of child abuse where the desired effect, rather than direct harm to the child, is attention from the medical profession coupled with often harmful procedures and treatments.

We present an unusual case of MSBP in which saliva and blood was being placed in the ear and in which the patient's mother supplied video evidence.

## Case report

An eight-month-old boy attended the ENT department with his mother and grandmother. They were complaining of a history of a sticky and occasionally blood-stained discharge of the left ear. This had necessitated seven general practice (GP) and two casualty consultations over the last three months at which the examination had been essentially normal with occasional mucous discharge seen in the left ear. On examination in clinic both ears appeared entirely normal and ear swabs had produced no growth. Unfortunately he was non-compliant with impedance audiometry.

Three days later he attended again with an acute history of increased discharge which the patient's mother had videotaped. Examination of the videotape showed dark blood pooled in the left ear and smeared

over the face. By the time of examination the patient had been cleaned up and there was only a small amount of dried blood in the canal with no evidence of trauma.

He was reviewed a week later after a course of sofradex ear drops and was noted to have normal looking tympanic membranes but with some mucus on the outer surface of the left ear. Admission was arranged for an examination under anaesthetic at which some dried blood was seen in the canal but a normal looking dry middle ear was seen at myringotomy.

At his post-operative visit to the out-patient clinic, an initially dry ear was noted to be full of mucus after returning from the audiology department. The mucus type and location was suspicious. It contained bubbles which made a middle-ear discharge seem unlikely, especially as the presence of a salivary fistula had been excluded. The mucus also appeared to be extending from the conchal bowl into just the superficial part of the canal rather than draining from the canal into the conchal bowl as expected.

The video footage was examined by the consultant who considered it to represent blood coming from outside rather than inside the ear. The child was therefore admitted to the paediatric ward for observation under the joint care of the paediatric and ENT teams.

During his admission nursing staff noted that his mother would regularly present the child to them with mucus coming from a previously dry ear after a period alone with him off the ward. The discharge was tested and found to contain amylase, which in the absence of any evidence of a fistula, suggested it was maternal saliva.

A case conference was called which revealed that both the mother and grandmother had themselves been abused and that all three slept in the same room in their council house. The father was a drug abuser who only occasionally visited. The mother initially denied the allegations and the grandmother accepted responsibility. Later the mother admitted guilt and the child was subsequently taken into foster care.

## Discussion

There is some debate about whether MSBP is under- or over-reported. Zohar *et al.* feel that the true prevalence may be less because the same patients often present to multiple hospitals, under different aliases, in order to get attention and are thus inadvertently presented as separate cases.<sup>3</sup> They give an example of a woman with Munchausen's syndrome who presented with 25 separate disorders to different departments over a period of 24 years! A review of the literature by Schreier and Libow however concluded that the prevalence is probably greater than generally estimated, although there is no way of proving this.<sup>4</sup> McGuire *et al.* put the incidence at 2.7/1000.<sup>5</sup>

There have been several cases of MSBP specific to paediatric ENT practice.

- **In this case of Munchausen's syndrome by proxy (MSBP), aural discharge was mimicked by spitting into the ear of a young child. The child's parents supplied video evidence, apparently supporting their claim**
- **The authors review previous cases of MSBP as presented to the otologist**
- **Clinicians should be aware of factitious disorders if presentation of head and neck conditions in children appear unusual**

Zohar *et al.* reported two cases. The first, a five-year-old child, with bilateral mastoid cavities presented with chronic purulent otitis and multiple lesions in the external meatus, on numerous occasions, which were the result of lesions inflicted by the mother. The second was a boy who presented repeatedly with chalk in his ear. The father was recognized as a previous patient who had refused to remove his drains after a maxillary sinus washout.<sup>3</sup>

Mra *et al.* reported a case of cerebrospinal fluid (CSF) taken from a child's lumbar drain and being soaked into the surgical dressings to give an illusion of CSF otorrhoea. Unfortunately, the child underwent two unnecessary major ear operations looking for the leak before nursing staff became aware of the real situation.<sup>6</sup>

Bourchier presented a child with maternal blood (of unknown source) placed in the child's ear. MSBP was eventually diagnosed by blood grouping.<sup>7</sup>

Griffiths *et al.* described a case of an 18-month-old child with granulation tissue and bleeding ears which led to an unnecessary mastoidectomy.<sup>8</sup>

Bath *et al.* published a case of recurrent episodes of apnoea in a four-month-old baby which only occurred after the father had been alone with him.<sup>9</sup> Shockingly the baby's sister had died in similar circumstances.

Video evidence, without the parent's knowledge, has been used to prosecute abusers in the past<sup>10</sup> but this is the first case where it has been supplied by the parent themselves. In their desperation to get attention from the medical profession, we increasingly expect digital photography and video to be used by abusers.

Typical features of MSBP (adapted from Meadow 1982)<sup>11</sup> are:

- Unexplained persistent or recurrent illness
- Investigation results at variance with apparent health of child
- Experienced physicians have 'never seen a case like it'
- Signs and symptoms do not occur when the mother is absent

- Over-attentive mother who will not leave the child
- Treatments not tolerated
- Very rare disorder as the primary diagnosis
- Mothers' response either inappropriate or complain that too little is being done
- Mothers with histories of Munchausen's syndrome or abuse
- Mothers from paramedical backgrounds
- Absent fathers
- Mothers with photographic/video evidence (new)

Our case demonstrates almost all of the above features, especially regarding the home circumstances. Neither of the senior authors had 'seen a case like it'.

The best treatment is always immediate consideration for the child's safety. Involve an experienced paediatrician at an early stage and admit the child to the ward for protection and observation. Once the diagnosis is certain, confronting the abuser may stop the abuse even if it is vigorously denied.<sup>11</sup> Although there may be no evidence of psychiatric illness in the mother, a common finding in the Meadow's paper,<sup>12</sup> psychotherapy has been used with some success for this condition.<sup>13</sup> In the experience of Mra *et al.*, Bath *et al.* and our own study, the end result is usually the removal of the child from the mother and placement under foster care.

As otorhinolaryngology encompasses a paediatric specialty it is essential for doctors to be vigilant and be opened to the possibility of MSBP in its many guises.

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