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Munchausen syndrome by proxy: otolaryngologists beware!

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Abstract
Munchausen syndrome by proxy (MSBP) is a rare condition in which a parent or guardian fabricates an illness in a child either by inducing physical signs or prevaricating. A case presenting as recurrent episodes of infant apnoea is reported. A high index of suspicion is required for the diagnosis and, therefore, the otolaryngologist must be familiar with the condition if the life of the infant is to be protected and potentially harmful unnecessary investigations are to be avoided.

Key words: Munchausen Syndrome, by proxy; Parent-child relations; Infant apnoea.

Introduction

Munchausen syndrome by proxy (MSBP), first described by Meadow (1977), occurs when a parent or guardian falsifies an illness in a child either by inducing physical signs of illness or by deliberately misleading the physician into believing the child is ill. Any system of the body can be involved but recently there have been several reports in the general paediatric literature of MSBP presenting as infantile apnoea (Rosen *et al.*, 1986; Makar and Squier, 1990; Meadow, 1990; Samuels *et al.*, 1992). We report a case of MSBP presenting to the otolaryngologist as recurrent apnoeic episodes.

Case report

A boy underwent a simple vaginal delivery at term after an uneventful pregnancy. He weighed 3.4 kg at birth and his neonatal progress was unremarkable. At one month of age he was admitted to a general paediatric ward having suffered an apnoeic attack. A stepsister aged 16 months had had a four month history of recurrent apnoeic episodes which eventually proved to be fatal. No specific underlying pathology had been found at postmortem. The boy experienced no apnoeic episodes during hospitalization and was discharged home four days later with an apnoea alarm.

After four months, during which the boy failed to thrive and had three further episodes of apnoea he was referred to an otolaryngologist. Clinical examination was unremarkable and at endoscopy the upper aero-digestive tract was found to be normal. During recovery from the anaesthetic he had an apnoeic episode and regurgitated his feed necessitating a 24 hour observation period in the paediatric intensive care unit. There were no untoward sequelae and he was returned to the ward for further investigation.

The following investigations were normal: urea and electrolytes, liver function tests, calcium and phosphate, air blood gases, amino acid chromatography, chromosome analysis, urine metabolic screen, echocardiogram, 24-hour electrocardiogram, electroencephalogram and overnight sleep study. The haemoglobin was slightly depressed for his age at 8.8 g/dl and the platelet count elevated at 738,000/ml. The borderline haemoglobin may have been due to a dietary insufficiency and the raised platelet count a response to stress.

During the next fortnight he gained 1 kg in weight but had four further episodes of apnoea. During each episode the father was present and alerted the nursing/medical staff. He responded well to oxygen on three occasions but the fourth required cardiopulmonary resuscitation. Following this he was transferred to the paediatric intensive care unit where he had one to one monitoring by the nursing staff. No further episodes of apnoea occurred.

Suspicions were aroused and a more detailed history was obtained. The dead stepsister's apnoeic attacks only started when the boy's father began cohabiting with the mother. Following the girl's death he was imprisoned for an unrelated matter, during which time the boy was born. His apnoeic episodes only started after his father had been released and the beginning of each episode was witnessed *solely* by the father.

A primary care conference was convened with the social services and police, and an interim wardship was agreed. Both parents were denied access for 28 days during which time the boy remained asymptomatic. The diagnosis of MSBP was confirmed. The father was subsequently convicted and is presently serving five years imprisonment. The boy is now 19 months of age and continues to thrive with no further attacks of apnoea.

Discussion

Munchausen syndrome by proxy may have various presentations depending upon which system of the body is affected (Meadow, 1977; Shnaps *et al.*, 1981). However, certain features in each case may alert the physician that the presenting illness may be fabricated (Meadow, 1985):

— symptoms and signs that appear incongruous to known pathophysiology
— treatments which are ineffective or poorly tolerated.
— symptoms and signs that *begin* only in the presence of one particular carer.
— parents who are unusually calm for the severity of the illness.
— families in which sudden unexplained infant illness or deaths have occurred.

Undoubtedly, children left in the care of an abusing parent are at risk of further morbidity, whether it be physical or psychological (McGuire and Feldman, 1989), and even possibly death. It is, therefore, imperative in such circumstances to confirm the diagnosis in order that the appropriate management can take place. To prove fabrication, as much information as possible must be obtained in order that definitive proof of falsification is justified. In the child that is suffering recurrent attacks of apnoea or cyanosis this should involve recordings of physiological signs, e.g. electrocardiogram, electroencephalogram, overnight sleep study (including pulse oximetry, respiratory effort and airflow). The

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most incontrovertible evidence in recent years has come from video evidence without the parents' knowledge (Southall *et al.*, 1987; Williams and Bevan, 1988). In these cases it is necessary for early liaison with social services, as with every potential case of child abuse. Having confirmed the diagnosis a multidisciplinary case conference is then required to decide the appropriate management of the child which in many cases entails separation from the abusing parent.

The reasons behind the cause of this syndrome are at present poorly understood. Subsequent psychiatric evaluation of parents has revealed no evidence of mental illness, although a childhood history of abuse may be of importance in that this behaviour may become projected onto the child (Nicol and Eccles, 1985). Whatever the reason for MSBP the otolaryngologist must be aware of this entity if the life of the unfortunate child is to be protected and potentially harmful, unnecessary investigations are to be avoided.

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