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Abdominal panniculitis as a presentation of Munchausen Syndrome

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ABSTRACT

Factitious disorders including Munchausen's syn drome are encountered by all clinicians. A considerable number of cases of Munchausen's syndrome are under-diagnosed in clinical practice. We present a 34-year-old man who was admitted with symptoms of epigastric pain, vomiting and peri-umbilical ecchymosis. Physical examination showed signs of inflammation in the abdominal wall with tenderness and guarding in the upper abdomen. However, various blood tests were unremarkable. Computed Tomography and demonstrated anterior abdominal wall panniculitis. After many investigations looking into various aetiological factors that could lead to fat necrosis, a diagnosis of Munchausen's syndrome was made and the patient was discharged to the care of the local general doctor practice following psychiatric input.

Keywords: Munchausen Syndrome; Abdominal Panniculitis

1. INTRODUCTION

Lying to receive attention is not a new concept. This disorder was formally recognized for the first time in the far 1800s, and evidence of malingering dates back as far as Roman times [1]. The first description of this syndrome was made by Richard Asher in 1951 [2], and he coined the term "Munchausen's Syndrome to describe an extreme form of factitious disorder, where the patient moved often to several hospitals with plausible symptoms apparently requiring urgent treatment. Later in 1977 Roy Meadow coined the term "Munchausen Syndrom by proxy" to describe the intentional false reporting of symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role [3]. Nowadays the increasing use of the internet to provide support for illnesses and other medical issues has introduced the concept of "health-related online identity deception-Munchausen by internet" (identified in 2000) [4].

2. PRESENTATION

A 34 years old man, usually fit and well, moderate alcohol abuse with 20 units a week, presented to the surgical department with vomiting and severe epigastric pain radiating to his back. Acute pancreatitis was hypothesised based on his alcoholic habit and on his clinical examination findings that were suggestive of abdominal wall inflammation with inspection demonstrating peri-umbilical ecchymosis consistent with likely Cullen's sign and guarding in epigastrium (**Figures 1** and **2**).

Blood tests failed to demonstrate a serum Amylase rise and his inflammatory markers (C-Reactive Protein and White Cell Counts) were within the normal range for our population. This soft presentation ruled out the diagnosis of acute pancreatitis. His Glasgow score at presentation and at day two was zero.

There was no relevant past medical history. A conservative management was considered but the pain and its clinical severity was actually increasing along with the extension and worsening of the abdominal wall ecchymosis.

In day five of his hospitalization because of unsettling but progressive pain a computed tomography (CT scan) was requested. The procedure was reported as normal for any intra-abdominal pathology including a normal pancreas, however, a significant anterior abdominal wall panniculitis was reported (**Figure 3**).

Clinically, his ecchymosis then developed, over several days, to include both flanks and his lower back (**Figure 4**). Microbiologist and Plastic Surgeons ruled out

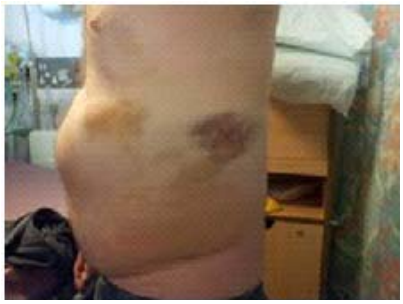

Figure 1. Ecchymosis—peri-umbilical and flanks.

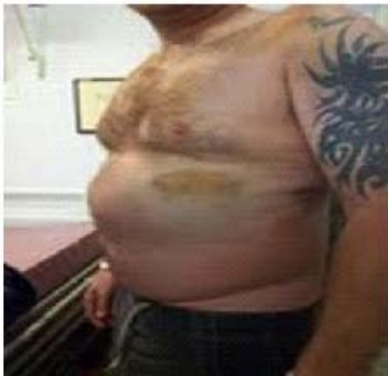

Figure 2. Ecchymosis—flanks.

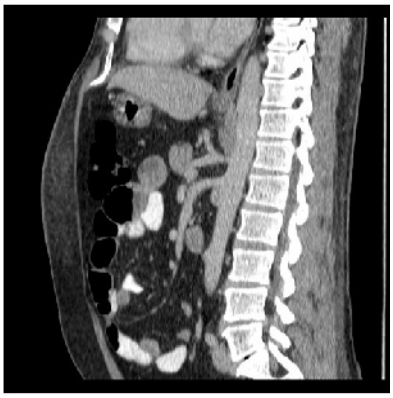

Figure 3. Reconstructed CT demonstrating anterior abdominal wall panniculitis.

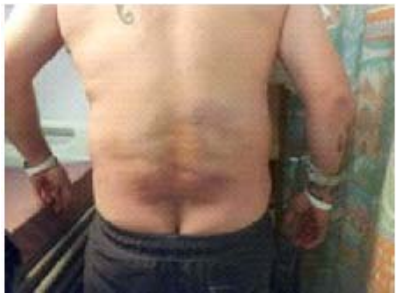

Figure 4. Ecchymosis in both flanks and lower back.

a diagnosis of necrotising fasciitis. A punch biopsy was performed by Dermatologist and demonstrated neutrophillic invasion of fat but no other pathology.

Unexpectedly, during his stay in hospital, he was allegedly witnessed to severely punch himself in the above mentioned areas several and repeatedly times with strong force in 4 separate episodes.

A Psychiatrist review was requested and a Munchausen's syndrome was diagnosed. This was based on his clinical presentation, past medical history and according with the patient notes collected from different local hospitals and local GP surgery where he had previous admission or attended with similar episodes of self harming.

The patient was discharged home advising him that the areas of induration and swelling over the ecchymosis due to the panniculitis will take several weeks to reduce in size and pain.

The psychiatric assessment before discharge did not recommend any further psychiatry input as he was deemed to be of low risk to his life and of others.

3. DISCUSSION

We presented a clinical case of a patient whose initial presentation was interpreted and initially managed as probable acute pancreatitis but after thorough investigations a diagnosis of Munchausen's Syndrome was made.

Münchausen syndrome is a psychiatric factitious disorder where in those affected feign disease, illness, or psychological trauma to draw attention or sympathy to themselves. It is also sometimes known as hospital addiction syndrome or hospital hopper syndrome. Nurses and doctors sometimes refer to them as frequent flyers, because they return to the hospital just as frequent flyers return to the airport. However, there is discussion to reclassify them as somatoform disorder in the DSM-5 as it is unclear whether or not people are conscious of drawing attention to themselves [5].

People with Münchausen syndromes deliberately produce or exaggerate symptoms in several ways. They might lie about or fake symptoms, hurt themselves to bring on symptoms, or alter diagnostic tests to draw attention or sympathy to themselves [6,7].

The exact cause of Munchausen syndrome is not known, but researchers believe both biological and psychological factors play a role in the development of this syndrome.

In this context, admitting a patient in the hospital with past medical history and a clinical sign of a specific condition clearly leads the investigations and the management toward a clinical direction rather than a psychiatric review and this represent a significant loss in the general economy of a hospital.

Doherty and JD Sheehan described patient with global

amnesia, the media publicized his story and printed his picture, also interpol were involved. After two weeks another man came to the same hospital with same symptoms but clinicians referred there were no symptoms of psychosis elicited and no evidence of cognitive impairment. After three days a telephone number was found on his person, this transpired to be his father's number that said the patient was waiting for admission to the local psychiatric hospital because of paranoid schizophrenia.

After two weeks the same patient was admitted to the orthopaedic ward with multiple fractures having fallen from scaffolding. He described delusion of persecution and passivity and a diagnosis of Munchausen Syndrome was referred [8].

Faida, Smith *et al*. described a rare case of Lobular Panniculitis, a 40-year-old female was hospitalized to investigate numerous painful unilateral ecchymoses found on her right lower leg. She denied any history of trauma. During hospitalization new ecchymoses were noted and also a worsening of the patient's pre existing lesion. After more exams and days on charge all the symptoms resolved spontaneously. A late X-ray of the leg showed the presence of a sewing needle into her calf. After this, the patient became aggressive and attempted to jump out of the hospital window, fortunately the staff were able to stop her. The patient refused any further medical assistance or psychiatric follow up so she discharged herself from hospital, and the psychiatric team referred a severe Munchausen Syndrome [9].

Goto and Sasajima described a 64-year-old man admitted to the hospital after head injury. Ct and Mr imaging revealed a mass with edema in the right frontal lobe. This mass was surgically removed and the authors noticed a small bone defect in the frontal bone above the brain abscess. The patient presented atypical seizures several times, and after the discharged of the patient he was hospitalized again because the wound had reopened. After the second surgery he stabbed a nail into his head where the bone had been removed due to the previous surgery, and presented intraventricular hemorrhage that decreased in size with non-surgical treatment. So the patient was referred to the psychiatry department with a diagnosis of Munchausen Syndrome [10].

In particular, consider this patient as affected by an attack of acute pancreatitis was clinically reasonable. However, is commonly known that serum amylase is insufficiently sensitive in severe pancreatitis, but also needs to be aware that a normal serum amylase does not exclude severe forms of acute pancreatitis, which are associated with a high morbidity and mortality [11-13] this is mainly due to the fact that amylase is rapidly cleared from the kidneys, and this, along with other factors, may lead to a normal serum amylase level even in the presence of necrotising pancreatitis [14-16]. Acute pancreatitis may occasionally be complicated by panniculitis as a result of the release of pancreatic enzymes, occurring in 2% - 3% of all patients with pancreatic disorders [17-19].

In our case, the peri-umbilical ecchymosis which were thought to be Cullen's sign helped actually to rule out the diagnosis of pancreatitis as this sign is associated with severe pancreatitis and was not compatible with the soft clinical presentation of our patient [20].

In conclusion, this brief report describes an atypical presentation of Munchausen Syndrome which misleads the clinicians producing a false diagnosis of acute pancreatitis [21]. This resulted in 10 days of investigations and hospitalization that incurred a considerable waste of professional time at huge economic and financial costs. A high index of suspicion for mental illness is urged in patients who present with this picture.

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