CASE REPORT

Munchausen Syndrome by Proxy Presented with Multiple Bone Fractures

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ABSTRACT

Munchausen Syndrome by Proxy (MSBP) is about the caregiver (perpetrator) who abuses and reveals signs of a disease of the victim because of her/his own psychological needs such as attracting and getting attention. Munchausen Syndrome by Proxy is a complicated form of. child abuse form, which may cause important physiological and psychological effects and has mortality risk in the long-term period. In a study, 93% of the cases found the perpetrator to be the mother, followed by the female babysitter and the father. Usually, the symptoms disappear during the mother's or the caregiver's absence. The more frequently reported findings are bleeding, apnoea, nutritional problems, vomiting, diarrhoea, convulsion, cyanosis, asthma, allergies, fever and pain. In studies conducted, the death rate is reported to be between 6% and 10% in the victims. Common opinion is that if no response is received from the practitioners in the treatment or if insufficient progress is shown (e.g., in a six months period), victims should be taken from their environment and should not be given back to their families. Here, we are representing a female perpetrator of MSBP who gives damage to her children by traumas like recurrent bone fractures and tissue damage, and as a result of a forensic notification, whose children are taken away and given to foster care.

Keywords: Bone fracture, child abuse, Munchausen syndrome by proxy

INTRODUCTION

Munchausen Syndrome by Proxy (MSBP) is about the caregiver (perpetrator) who abuses and reveals signs of a disease of the victim because of her/his own psychological needs like attracting and getting attention. Munchausen Syndrome by Proxy may cause physiological and psychological effects and has mortality risk (1). Here, we present a case of MSBP by a mother who injures her children by producing traumas such as recurrent bone fractures, and result of a forensic notification, whose children were taken away and placed in foster care.

CASE REPORT

A 34-year-old woman with six children brought her 5-year-old son to the emergency room with a complaint of right leg pain. She mentioned that her son fell off a broken ladder in their house. In his physical examination, there was sensitivity in the right leg and the complaint of pain that occurred with moving. In conventional radiography of bilateral lower extremity, a fracture in the right tibia was detected; the right leg was encased in plaster and the boy was discharged with follow-up recommendation. About two weeks later, she brought her 7-year-old son to the emergency room with difficulty in walking, bruises and scars on his legs his legs. She stated that her son fell down the stairs. As a result of the conducted analyses, no fractures were detected, though new bruises made the orthopaedist suspicious. He was admitted to the orthopaedic clinic and was taken under treatment. Three months later, the same woman brought her 12-year-old child to the emergency room with similar complaints. The orthopaedist, suspecting child abuse, requested psychiatric consultation and called the hospital police. In her psychiatric examination, she was conscious, fully cooperated to time-place-person. Her affect was blunted, and speech was in the form of question and answer. No perception and/or thought content

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abnormality was seen. Her intelligence quotient score was 83, implementing as dull intelligence level. The impression from the clinical observation was borderline mental capacity. In her anamnesis, she reported that her husband was a long-distance driver, and because of that she has been spending most of the days of the year alone with her children. When the past hospital records about the family were investigated, it was found that there were many emergency appeals about her children. On physical examination, the children had scars, and X-rays of the legs revealed older fractures from different time intervals. Further anamnesis revealed that she had been causing fractures and bruises to her sons using her husband's truck wedge. It was also learned that she had been informing her husband about the illnesses and hospitalisation of the children prompting him to return home earlier than usual and spend more time together. This situation was reported to the forensic units; and the children were taken away from their parents and placed in a state institution where they will be taken care of.

DISCUSSION

Munchausen Syndrome by Proxy, according to the types of other child abuse, is quite common and incidence studies in children under the age of 16 years reported a rate of 0.4/100 000, whereas under the age of one year, the rate was 2–2.8/100 000 found. However, the actual incidence is higher than this estimated amount (2–5). One study showed that in 93% of cases the perpetrator was found to be the mother, similar with our case, and according to the order of frequency, the other implementers were babysitter and the father (5). In the MSBP, the symptoms, physical findings and laboratory results can be extraordinary, and usually inconsistent with the patient's situation and history. The relationship between the disease's clinical findings and prognosis cannot be established.

Patients usually do not respond to the treatment, or even if they do at the beginning, symptoms recrudescence afterwards (6). Usually, the symptoms disappear during the caregiver's absence (7). Due to the continuous applications to emergency service, diagnosis may go unnoticed. Most of the time, the doctors involuntarily get involved to this period with performing unnecessary diagnostic and interventional procedures or prescribing drugs that have a high potential for side effects. Victims' 75% of morbidity was found to be as a result of initiatives that are performed by the doctors in the hospital (3). MSPB is a form of child abuse, which has quite a high risk of morbidity and mortality. In studies conducted, the death rate is reported to be between 6% and 10% in the victims. In addition to this, if the victim is poisoned or suffocated, the death rate increases up to 33% (3, 5). In this syndrome, it is hard to understand the underlying psychopathology of the practitioner. It should not be forgotten that there is no diagnostic test or psychological profile that excludes or supports the diagnosis of the MSBP. In the MSBP, narcissistic fragility and borderline personality traits are frequent; also passive-dependent, hysterical personality traits, different sadomasochistic behaviours, mild or borderline mental retardation, compliance issues and depression have been found (8). In our case, the patient was thought to have a borderline mental capacity. This situation may have influenced the mother's executive functions negatively, so that she could not find an alternative solution to absence of her husband in order to spend more time with him.

It is known that MSBP has a high relapse risk (9). In our case, a rare type of MSBP is studied that occurred with repetitive bone fractures in multiple family members. It has been noticed that the mother was trying to draw attention by creating these bone fractures and intended to spend more time with her husband. Another MSBP case diagnosed on suspicion after 11 months of having repetitive humerus, femur and tibia fractures and skin lesions in a 3-year-old victim. The mother created disease symptoms on the child in order to maintain her own psychological needs and tried to organise her husband and spend more time with him (10). There are limited number of studies about long-term follow-ups of the victims who were exposed to this childhood abuse. In these studies, it is reported that starting from childhood and continuing in adulthood, the victims may develop problems like insecurity, being opposed and oppositional defiant disorder, post-traumatic disorder, attention disorders, attachment and social relationship problems, avoiding medical treatment and low self-esteem. What is more, it is found that some of the victims developed 'Munchausen Syndrome' in their adolescence and young adulthood (1, 11). In our case, information on the progress of the victims could not be obtained because they were placed in foster care. Making a diagnosis is usually hard; if any case is considered to be MSBP, it should be approached in a suspicious manner to each case. It is important to remember that the first condition of the diagnosis is to be suspicious; if there are any diagnosis of suspected MSBP cases, a retrospective review of them and their siblings should be performed.

As we did in our case, investigating the hospital records of the patient's siblings is important for the

diagnosis. A collaborative work of a multidisciplinary team provides guidance for the diagnosis of MSBP. Priority should be given to the victim's safety while collecting the necessary evidence for the diagnosis, and child's life should not be at more risk. Common opinion is that if no response is received from the practitioners in the treatment or if insufficient progress is shown (*eg*, in 6 months period), the victims should be taken from their environment and should not be given back to their families. Due to the high risk of recurrence in the children who are given back to their families, close monitoring and follow-ups are recommended (3, 9). The children in our case were taken from their families and have been taken under the state protection. We cannot give further information about the current status because we could not follow the family further.

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