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CASE REPORT

RECURRENT HAEMETEMESIS: THE MYSTERY UNFOLDS

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ABSTRACT: This report presents the case history of a six year old child who was portrayed as having recurrent haemetemesis since two years by her mother. A detailed evaluation showed that the patient's history was inconsistent with the clinical findings and investigations, leading to a diagnosis of Factitious Disorder by Proxy (FDbp). The report highlights the rationale for under-diagnosis of FDbp in India and challenges the conventional approach (Parentectomy) for treating FDbp.
KEYWORDS: Factitious Disorder by proxy , child abuse , marital disharmony , inconsistent

CASE REPORT: A six year old girl born out of consanguineous marriage was admitted to the paediatric ward by her mother with the complaints of recurrent haemetemesis, associated with pain abdomen and headache since two years. There was no history of drug ingestion, food allergy, pica, foreign body ingestion contact with tuberculosis or blood transfusion. There was also no history suggestive of delayed milestones, subnormal intelligence, temper tantrums, depressive illness or any other behavioral problems.

The child was an inpatient to four other hospitals in the city over the last two years and not been attending the school since then. She was thoroughly evaluated for the same problem in all the four hospitals, with no significant positive report. A detailed examination of the child was done in our hospital on admission which appeared normal. Physical examination revealed a conscious, well-oriented, non-co-operative child with an unusually loving, caring, possessive and overprotective mother always by her side. All baseline investigations – Complete blood picture, hepatic and renal functions, coagulation profile, mantoux test, chest X ray, stool for microscopy and occult blood were normal.

Upper gastrointestinal endoscopy was done at another hospital, but it did not reveal any pathology. On the fourth day of the admission, the mother seemed anxious, possessive and told us that the vomiting persisted and there was no improvement in spite of the treatment. When the mother was asked to preserve the sample of vomitus, she expressed her inability to collect the sample as the child had been vomiting in the toilet. This raised the suspicion as to how a six year old child could hold back the vomiting each time until she reached the toilet. The suspicion was heightened when she said that the vomiting stopped abruptly the next day.

Neither the nursing staff nor the resident doctors had witnessed the child vomiting ever since she was admitted to the ward. During the period of hospitalization, none of the other family members have visited the child. Finally when the clinical findings and investigations were found to be inconsistent with the history and after excluding all the organic causes of recurrent haemetemesis, the mother was taken into confidence, by carefully probing into the family and social issues. She revealed about her marital disharmony, that her husband was a chronic alcoholic, who physically abused the family members and did not lend any financial support. After initial hesitation, the mother

started accepting her involvement in fabricating the symptoms and therefore wanted to get discharged.

Based on the following Features:

- Frequent hospitalizations.
- Inability to collect/preserve the sample of vomitus.
- Symptoms stopping abruptly, few days after admission.
- Unusually possessive and over-protective mother.
- None of the other family members visiting the child.
- Neither the nursing staff nor the resident doctors witnessing the vomiting.
- Family & social issues (marital disharmony).
- Discrepancy between the history and clinical findings.
- Normal investigation reports.
- Insisting on getting discharged.

The diagnosis of Factitious Disorder by proxy (FDbp) became a distinct possibility. Accordingly the mother was counseled, referred to a Psychiatrist for further management and advised to bring the child to Paediatric outpatient clinic for regular follow up. The mother attended the Psychiatric outpatient clinic with her daughter after missing two appointments. During the Psychiatric assessment, the mother appeared to be guarded and indifferent. The mental status examination of the mother revealed a depressed mood, but the child revealed no psychopathology.

After the initial assessment she was given another appointment after a week and was advised to come along with her husband. Subsequently we tried to contact her, but were unsuccessful in tracing her.

DISCUSSION: Asher[1] coined the term Munchausen Syndrome in 1951 and the term "Munchausen Syndrome by Proxy" was coined by a Physician Roy Meadow[2] in 1977, which has been replaced by the term "Factitious Disorder by Proxy". It is a rare form of child abuse which is commonly seen in preschool children where the caregiver (mostly the biological mother) being the perpetrator, fabricates an illness, which is usually acute, dramatic and convincing in order to keep the child in prolonged contact with the healthcare providers.[3]

CRITERIA: According to the diagnostic and statistical manual of mental disorders (DSM V) the research criteria for factitious disorder include:

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another associate with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired or injured.
C. The deceptive behaviour is evident even in the absence of obvious external rewards.
D. The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

NOTE: The perpetrator, and not the victim receives this diagnosis.[4]

However, there are no available statistics of FDbp in India, because many cases go unrecognized and under-diagnosed with low suspicion index and even if diagnosed, are seldom reported.

FDbp should be considered whenever the child presents with an unusual illness and has negative work up or an atypical response to standard therapy.[5] In the above cases, all possibilities of an organic illness have been ruled out after a thorough clinical evaluation and investigations. In rare circumstances as in FDbp, it becomes imperative to rule out any other organic illness, however remote, before arriving at the diagnosis.[6] It is also important to differentiate FDbp from Anxiety Disorders, non-compliance and malingering with the goal of some external gain.[7]

AN EARLY DIAGNOSIS IS ABSOLUTELY ESSENTIAL: Therefore, eliciting a detailed social and family history is crucial for identifying the dysfunctional family dynamics and psychiatric morbidity in the genetically related. But once the diagnosis has been clinched, the mother should be confronted in a non-judgmental and non- accusatory manner, as some mothers develop depression and suicidal tendency, following such a confrontation.[8] The Psychiatric treatment of the mother (Perpetrator) is an absolute must to prevent recurrences of abuse in the future.

The diagnosis and cure for FDbp in most of the countries is to separate the child from the perpetrator, a total "Parentectomy".[9] But in India with poor socio-economic conditions and absence of a robust social safety net, the goal of therapy should be focused on involving the entire family. Ongoing family issues must be addressed to guarantee the future safety of the child as marital discord was the triggering factor in this case. Grandparents and other close relatives should be involved in providing support to the family, as they may have deeper insight as to what is happening at home.

In children who are victims of FDbp, the psychiatric morbidity ranges from development of behavioral problems, hysterical disorders depressive illness and anxiety disorders. It is extremely important to raise awareness of FDbp among the medical fraternity and to work towards ensuring that children do not fall victim to this illness at the hands of their own parents. Unless FDbp is recognized in our society, it will continue to go unnoticed with serious repercussions on the physical and mental health of children and their caregivers.

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