Munchausen syndrome presenting in a patient who has undergone temporomandibular joint surgery

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Munchausen syndrome is a rare psychiatric disorder. Patients with Munchausen syndrome insist on and repeatedly undergo unnecessary investigations and operative treatments. No organic pathosis is demonstrated, and treatment consistently fails to alleviate the symptoms. This article presents a case report and a brief discussion to facilitate recognition and management techniques. (Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2001;91:20-22)

The American Psychiatric Association’s Diagnostic and Statistical Manual, 4th edition (DSM-IV) classifies Munchausen syndrome as a subtype of factitious disorder. The DSM-IV divides factitious disorders into 3 types: factitious disorder with predominantly psychological signs and symptoms; factitious disorder with predominantly physical signs and symptoms; and factitious disorder with combined psychological and physical signs and symptoms. Despite problems with the term, the Munchausen eponym persists when referring to cases of factitious disorder. It should more appropriately be reserved to designate a small subset of individuals with factitious disorder.

Patients with factitious disorders can be represented as a continuum. On the benign end are school children who use physical symptoms (eg, a stomachache) to avoid going to school. On the malignant end of the spectrum are cases of chronic factitious disorder, or Munchausen syndrome, in which self-induction of dramatic illness allows the patient to achieve the goal of multiple hospitalizations. More recently described is factitious disorder by proxy (sometimes called Munchausen by proxy), in which signs and symptoms are created in another person, usually a child. This very disturbing discovery provides insight into children whose recurrent illnesses had previously seemed inexplicable.

Few patients have been recognized or described with Munchausen syndrome presenting with orofacial complaints. The purpose of this article is to report an unusual case of Munchausen syndrome in a patient who had undergone multiple temporomandibular joint (TMJ) surgeries.

CASE REPORT

A 32-year-old divorced white woman presented with a history of 10 previous TMJ surgeries by multiple surgeons. The operative procedures included left disk repair (1985); right disk repair (1986); right diskectomy with silicone fossa implant (1986); left diskectomy with silicone fossa implant (1986); removal of silicone implants (1987); bilateral costochondral rib grafts (1988); bilateral Vitek (Vitek, Inc, Houston, Tex) total joint replacements (1988); removal of total Vitek implants (1991); placement of Christensen implants (TMJ Implants, Inc, Golden, Colo) (1991); and removal of Christensen implants in 2 separate surgeries (1992).

The patient was seen by one of the authors (B. S.) for evaluation for bilateral total joint replacement with custom total joint prostheses.

The patient was in good health with no significant history of cardiovascular, pulmonary, hepatic, renal, gastric, or hematologic disorders.

Total joint replacement was done. The patient was followed-up after surgery for 9 days by the surgical team, and a psychiatrist and an anesthesiologist were consulted to help with pain management. All suture sites were healing normally, and the patient remained afebrile during her hospital stay. Within 24 hours of discharge, the patient reported a temperature of 103°F, swelling and redness in the right submandibular wound site, and increased drainage. The patient was seen in a local emergency room; no drainage or suppuration was found, and a culture yielded no growth. The patient was reevaluated the next day in the surgeon’s office, at which time she had a temperature of 100.5°F and a 2-cm wound dehiscence without any drainage. The patient was readmitted. The treatment plan...
consisted of intravenous antibiotics and possible wound debridement and removal of the right TMJ prosthesis. Findings of blood and urine culture, complete blood cell count with differential, electrolytes, and liver panel were normal.

The hospital nursing staff reported seeing the patient touching her incision sites. Further psychiatric evaluation was requested. The patient did not deny “picking at her wounds,” but stated that she did not do it consciously. Earlier hospital records did not show any history of self-mutilation. However, questioning her prior surgeons revealed that this patient had a tendency to manipulate her wound dressings and her temperature readings.

The nursing staff observed that the patient was inserting her finger into the wound. An occlusive submandibular dressing was applied. The patient managed to pry this loose and reopen the wound with her finger. The nursing staff used a 24-hour watch to prevent further manipulation. Once the wound was well protected and the patient was placed under constant observation, the site healed normally. The consulting psychiatrist felt there was abundant evidence to make the diagnosis of Munchausen syndrome.

At a 3-month follow-up the patient was doing well, there were no signs of tampering or mutilation, and all wounds were completely healed. The patient reported good results from the total joint replacement; however, she was lost to follow-up. Subsequently, she was seen in another part of the country where reportedly she underwent another surgery. The surgeon apparently did not contact any of her previous clinicians, and the patient never reported the previous incident relating to her wound manipulation.

**CLINICAL FEATURES**

Patients with chronic factitious disorder (Munchausen syndrome) are likely to present to the emergency department of a large teaching hospital during the evening hours or on the weekend because insurance offices are closed and less experienced house staff are on duty. The simulator’s dramatic presentation (eg, seizures or coma, profuse bleeding, severe chest pain) creates an immediate emergent response. Features typically encountered in these patients include simulated signs and symptoms of diseases, unusual or dramatic presentation, and peregrination or wide-spread travel associated with numerous hospitalizations. The most commonly reported symptoms and signs are hypoglycemic episodes, fevers of unknown origin, recurrent infections or abscesses, blood dyscrasias, neurologic disorders, and renal colic. As inconsistencies build, caregivers challenge the patient. The patient typically responds with anger (eg, demanding discharge against medical advice or threatening to file a lawsuit), renewed physical complaints, or disruptive behavior, or the patient simply disappears.

These patients are usually single women who have medical insurance and who are readmitted to the same hospitals. They become well known to the staff and regard themselves as special patients. They frequently provoke conflicts and emotional controversies among staff members, and some treatment team members do not accept the factitious nature of the symptoms, even when presented with unequivocal evidence. Family members typically are either overly involved with the patient or quite distant. The patient often has borderline personality traits, which can be evident on psychological testing, and a capacity for intimacy and mature sexual relationships is almost always lacking.

**ETIOLOGY AND EPIDEMIOLOGY**

Psychological factors, such as longing for nurturance, feelings of helplessness, desire to feel superior, and anger toward physicians, have been emphasized by authors. More recently, articles have emphasized underlying brain dysfunction in 20% to 25% of patients with Munchausen syndrome. Abnormalities have been reported in brain images and neuropsychological testing. Accurate epidemiologic data are unavailable because deception is an integral part of factitious disorders. Estimates of incidence, prevalence, and demographic characteristics must be gleaned from patient studies, reported series, and referral patterns. Analyses of patients with factitious disorders suggest 2 general patterns among individuals with chronic factitious disorder (Munchausen syndrome). One group consists of middle-aged, unmarried men who are estranged from their families, and the second group consists of women aged 20 to 40 who work in medical occupations, such as nursing or medical technology.

**DIAGNOSIS**

The patient with factitious disorder is usually discovered accidentally by finding incriminating items or unusual laboratory findings. Sometimes the diagnosis is made by exclusion in that no known disease could explain the findings. When factitious disorder is suspected or discovered, immediate psychiatric consultation is recommended. Patients with factitious disorder might have legitimate medical illness. Determination of both physical and psychiatric comorbidity in patients with factitious disorder is essential to develop a sound management plan.

**DISCUSSION**

The first step in managing a patient with a factitious disorder is recognition of the problem, which is the main point of presenting this case. The clinician must be an astute historian; he or she must take a careful history from the patient, discuss previous care with the patient’s other caregivers, and finally, discuss any discrepancies with the patient. The clinician who suspects a simulated illness should communicate his or her concerns to the patient early in the diagnostic process. It is important to be nonconfrontive and nonadversarial in approaching the
patient. The goal of recognizing the diagnosis and keeping the patient involved is to set the stage for later effective therapeutic intervention. It is essential that a supportive, noncondemning approach be taken by the clinician, and it will be critical to consult with a psychiatrist in the management of such a patient.23 Inpatient psychiatric treatment can facilitate treatment, and subsequent outpatient psychotherapy can be beneficial. When comorbid psychiatric diagnoses are present, they should be treated vigorously.24 Ford and Feldman8 recommended following these guidelines when encountering a patient with factitious disorder:

1. Immediately involve the hospital administration.
2. Seek legal advice from the hospital’s risk management department and possibly from your own medical liability insurance carrier.
3. Consult early with the hospital’s ethics committee.
4. Maintain confidentiality to the extent specified by law.

The physician should schedule regular periodic examinations to provide support, even if the patient is actively involved in psychiatric treatment. New episodes of factitious illness behavior usually occur with confrontation or with perceived rejections, such as during the therapist’s vacations. The consistent support of the primary caregiver to provide support, even if the patient is actively involved in psychiatric treatment. New episodes of factitious illness behavior usually occur with confrontation or with perceived rejections, such as during the therapist’s vacations. The consistent support of the primary care physician and of the therapist should reduce the patient’s need for factitious behaviors.3

This case illustrates the need for those who treat orofacial pain to be well informed about chronic pain conditions and behavior such as Munchausen syndrome. The complex history of the chronic pain patient and the need for urgent treatment offer management challenges for all caregivers. When medical treatment is unsuccessful, caregivers often refer the patient for a surgical opinion, and the surgeon who is eager to operate might dismiss the previously unsuccessful surgical history, so the underlying problem is not addressed. Treatment of these patients will be more focused and directed if a careful history is taken and if previous caregivers are contacted to help the current caregiver fully understand what led the patient to his or her office.

This article does not suggest that multiple failed TMJ surgeries are diagnostic criteria for Munchausen syndrome; rather this unusual case will cause caregivers to consider a thorough approach to patients with complex pain. It is generally accepted in the maxillofacial surgery literature that chances of resolving pain for a patient without Munchausen syndrome after 2 to 3 surgeries is substantially reduced. The difficulties that are involved in diagnosing and treating patients with chronic pain are common to all caregivers, and together we must explore the treatment options, such as multidisciplinary pain programs, which have become more common and which provide us with treatment options that are in our patients’ best interests.

REFERENCES