

52-year-old man with recurrent urinary tract infection, Munchausen's syndrome



Varón de 52 años con infecciones de orina de repetición: síndrome de Munchausen

To the Editor,

Munchausen's syndrome is considered to be a factitious disorder with predominantly physical symptoms. It was first described by Asher in 1951¹ and, despite having passed 60 years, making an accurate diagnosis of factitious disorder is still as challenging for clinicians.

Individuals with chronic and severe forms change names and sometimes modify their stories to avoid tracking and long-term follow-up is rarely reported.² A retrospective study in a psychiatric centre found a 6% of prevalence.³ The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)⁴ defines that the characteristics of all forms of factitious disorder are intentional production of feigned physical or psychological signs or symptoms, presence of illness behaviour reflecting a wish to assume the sick role, confronting physicians with self-induced symptoms or disease and absence of external incentives (e.g., economic gain, avoiding legal responsibility, etc.)

These criteria define an extremely heterogeneous population with coexisting medical and psychiatric disorders and usually seen by non-psychiatrists. Therefore it is under-recognized and under-appreciated, leading to unnecessary morbidity and mortality, and tremendous cost to healthcare systems.^{5–7}

To illustrate the difficulties at arrive to a proper diagnosis we report a rare case of a man who visited repeatedly different hospitals with recurrent abdominal pain.

A 52-year-old man presented to the emergency department with dysuria, urgency, dark urine, right low-back and flank pain and an isolated temperature determination of 38.2 °C, with no other symptoms. When asked, the patient denied previous visits to other hospitals, despite we being able to see his past medical history. However, electronic records showed a previous admission at our centre in 2003 due to renal colic, without any evidence of urolithiasis that derived by the placement of a pigtail catheter due to persistence of pain. He was again admitted in 2012 due to chronic prostatitis by extended-spectrum beta-lactamases producing *Klebsiella pneumoniae* and pyelonephritis by *Streptococcus viridians*, receiving broad-spectrum antibiotics.

When going through his electronic medical records (due to hospital sharing of medical records), it was found that in the last 4 years, he had visited several emergency departments 103 times and had been hospitalized 10 times, due to recurrent abdominal pain and urinary tract infection. At these centres, multiple tests were run, including, ultrasounds, abdominal scans, MRI, barium enemas, urine cytologies, bone scintigraphy, and even a laparoscopic exploration; all of them without any alterations.

At the ED he impressed of severe pain, afebrile. He had painful abdominal examination in the right iliac fossa and right flank with right positive lumbar percussion. He had urinary analysis with 20–50 leukocytes/field and many bacteriae. Blood tests and abdominal ultrasound were normal. Broad-spectrum antibiotics were started and the patient was admitted with the diagnosis of pyelonephritis.

Past urinary cultures were reviewed from former visits to the emergency department, finding *Streptococcus viridians* in most of them or contamination. The patient denied having been hospitalised in other hospitals. Psychiatric disorder was then suspected. To check, urinalysis was requested without notice to the patient obtaining a normal result (no leucocyte, no bacteria). The day after the patient was asked for another urine sample that he provided,

with pathological result (haematuria, pyuria). In this sample amy-lasuria was determined (under the suspicion that the patient may be spitting on the urine to alter the results) with a result 10,433 IU/l (normal range 0–460 IU/l), and normal amylasemia. A third urine sample subsequently collected under the supervision of a nurse showed no pathological outcome and amy-lasuria within normality, thus proving the patient was deliberately contaminating the urine samples. Antibiotic treatment was withdrawn and assessed by psy-chiatry, which determined factitious disorder without psychotic clinic; he was discharged with outpatient psychiatric follow-up. Since he was discharged the patient has visited several emergency departments with the same symptoms, and has not attended the psychiatric visits.

The repeated history of abdominal pain, without any findings in the multiple tests that had been run in several hospitals, and the fact that the patient denied previous hospitalizations, led us to suspect Munchausen's syndrome. The use of shared electronic medical records was of extreme importance in order to suspect the patient's illness.

The prevalence of Munchausen's syndrome is difficult to ascertain and is likely to be underreported. Further diagnostic pro-cedures and treatment interventions can also cause more morbidity or mortality, by the intervention itself, i.e., our patient underwent a surgery, had placed a pig-tail catheter, received high doses of radiation due to repeated CT-scans (at least 11) and had high resis-tant microorganism flora due to repeated intake of broad spectrum antibiotics, or through the patient's contribution.

In cases of factitious disorder with physical symptoms con-frontation has been criticized mainly because it has been done aggressively, causing the rejection of any type of patient psychiatric treatment. The non-punitive confrontation, which reformulates the disorder as a request for help, promotes patient adherence to psy-chiatric treatment.⁸ Treatment of Munchausen's syndrome should focus on the underlying motivations. Unfortunately most patients refuse psychiatric help and leave hospital even before correct dia-gnosis is made.⁸

We should therefore suspect this disorder in patients with recurrent urinary tract infection, with polymicrobial or unusual flora (*S. viridans*), without evidence of urological anomalies (such as intestinal fistulae). The fact that culture of urinary samples pro-vided by urinary catheter or supervised by a faculty are negative should also give us a hint of the underlying disorder.

References

1. Asher R. Munchausen's syndrome. *Lancet*. 1951;1:339–41.
2. Fehnel CR, Brewer EJ. Munchausen's syndrome with 20-year follow-up. *Am J Psychiatry*. 2006;163:547.
3. Gregory RJ, Jindal S. Factitious disorder on an inpatient psychiatry ward. *Am J Orthopsychiatry*. 2006;76:31–6.
4. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5)*. Arlington, VA: American Psychiatric Association; 2013.
5. Aduan RP, Fauci AS, Dale DC. Factitious fever and self-induced infection: a report of 32 cases and review of the literature. *Ann Intern Med*. 1979;90:230–42.
6. Krahn LE, Li H, O'Connor MK. Patients who strive to be ill: factitious disorder with physical symptoms. *Am J Psychiatry*. 2003;160:1163–8.
7. Feldman. The costs of factitious disorders. *Psychosomatics*. 1994;35:506–7.
8. Plassman R. Inpatient and outpatient long-term psychotherapy of patients suffer-ing from factitious disorders. *Psychother Psychosom*. 1994;62:96–107.

Sabina Herrera*, Patricia Corzo, Ruperto-Carlos Oliverò,
Ana Zabalza, Roberto Carlos Güerri-Fernández

Department of Internal Medicine and Infectious Diseases, Hospital
del Mar, Barcelona, Spain

* Corresponding author.

E-mail address: sherrera@hospitaldelmar.cat (S. Herrera).

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