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CASE REPORTS

A CASE OF MUNCHAUSEN SYNDROME MASQUERADING AS UNSTABLE ANGINA

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The authors report the case of a man who presented with unstable angina and who, at different hospitals over a period of several months, underwent two heart catheterizations, intra-aortic balloon counterpulsation, and eventual bypass surgery despite essentially normal coronary arteries.

Munchausen syndrome is an emotional disorder in which an individual, without any underlying medical abnormality, presents himself to a physician as having serious illness. The history is usually grandiose, yet plausible. Such individuals manipulate members of the medical community into performing surgery or extensive medical treatment for questionable disease entities. When such patients are confronted with the possibility that they may be lying, they often terminate treatment against medical advice and refuse psychiatric assistance. Frequently, they will then go to another hospital in the community with a similar or slightly altered story and further medical or surgical treatment will be performed. The advent of advanced diagnostic and surgical interventions make it imperative that physicians carefully screen their patients.

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A case of this fascinating syndrome is presented in this communication.

CASE REPORT

Mr. H. presented to the University of California-Irvine Medical Center Emergency Room with a chief complaint of sudden onset of chest pain. According to the patient, he was 46 years old and had never had chest pain prior to the day of admission when, as the pilot of a 747 jet airliner, he had flown from New Zealand to Los Angeles. During the flight one of the engines "froze up." Coincident with this emergency situation the patient developed chest pain which radiated to the left arm. He described diaphoresis, nausea, and some dizziness along with weakness and numbness of the left arm. He landed the plane without further incident. However, the chest pain persisted for two hours and, therefore, he came to the emergency room.

The patient stated that he had been in good health prior to this episode and had recently undergone a treadmill stress test that his airline company performed once a year at Walter Reed Army Hospital in Washington. His only previous hospitalization had been for wounds and malnutrition after he had been shot down over North Vietnam and imprisoned near Hanoi for seven years.

Physical examination revealed a man who ap-

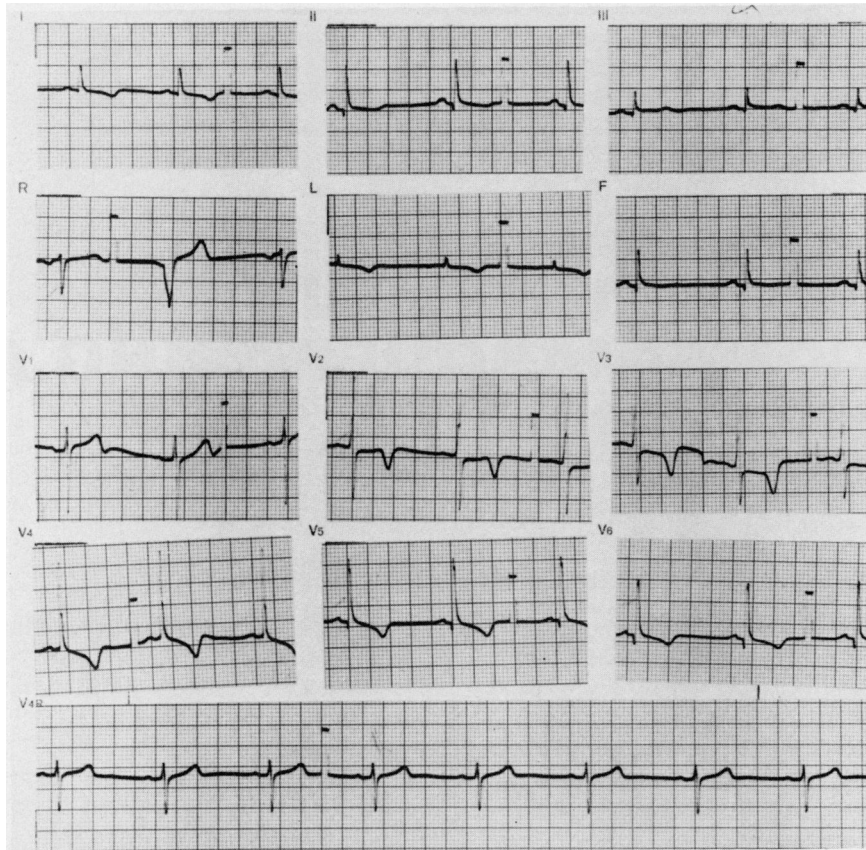


Figure 1. Twelve-lead electrocardiogram on admission. There was no change whether the patient had chest pain or was asymptomatic

peared ten years older than his stated age. He had left arm weakness, clear lungs, and no murmurs. His electrocardiogram (Figure 1) showed marked ST and T wave abnormalities that were felt to be consistent with acute myocardial ischemia. His cardiac enzymes and chest x-ray were normal. He was admitted to the cardiac care unit (CCU) with the diagnosis of unstable angina. He continued to experience more chest pain, which was only temporarily relieved with propranolol, nitroglycerin, and morphine. Despite this medical regimen, he had intermittent chest pain and hypotension; therefore, a Swan-Ganz catheter was inserted. This revealed normal pressures on the right side of his heart and a normal pulmonary wedge pressure. A resting thallium cardiac perfusion study revealed no abnormal defects and a gated pool wall motion study showed a normal ejection fraction without contraction abnormalities. On the fourth hospital day, the patient continued to have inter-

mittent chest pain despite maximum medical management. The patient was considered for intra-aortic balloon counterpulsation and cardiac catheterization with coronary artery angiography.

While the authors were discussing this mode of therapy, a new resident on the service made rounds in the CCU and recognized this patient as having been in the Long Beach VA Hospital approximately one month earlier, with a similar history and hospital course. At that time, a diagnosis was made of unstable angina refractory to medical therapy. The patient had an intra-aortic balloon placed with subsequent emergency cardiac catheterization and coronary angiography. That study was interpreted as showing normal coronary vessels. Following heart catheterization, the patient continued to complain of chest pain and demanded demerol. He signed out from the VA Hospital against medical advice when he was refused demerol. The patient also signed out against medical

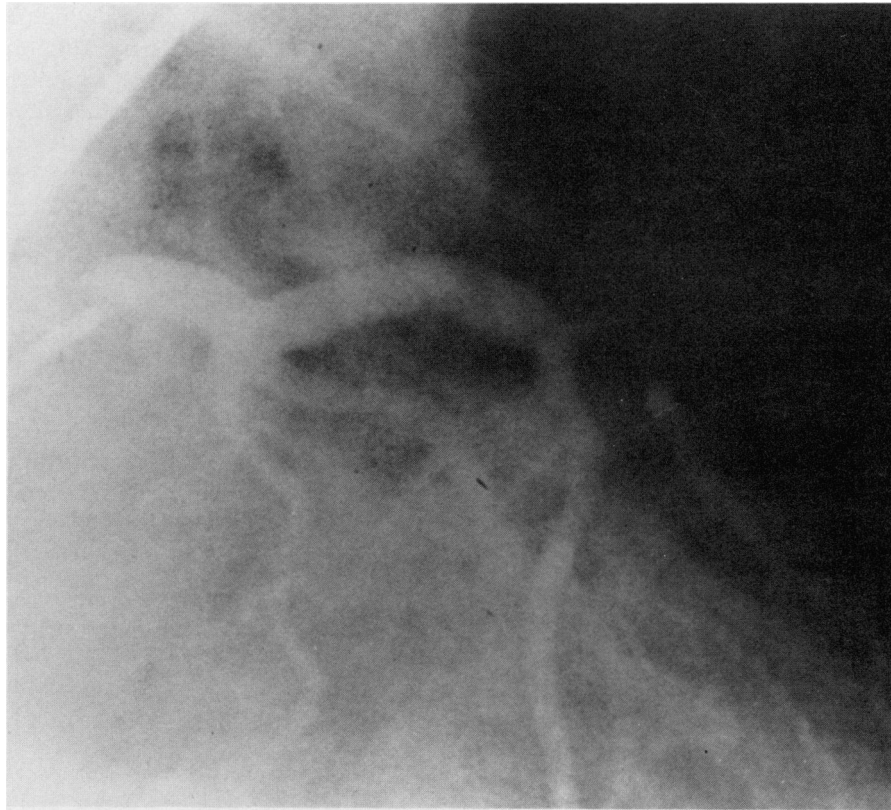


Figure 2. Coronary angiogram from a community hospital which was interpreted as showing a "75 percent proximal left diagonal" obstruction

advice from this institution after the resident had recognized him.

Within a month after discharge from this hospital, the patient presented to a local community hospital with a history of chest pain while enroute from overseas to this country. The patient was admitted with a diagnosis of unstable angina refractory to medical management. An abnormal electrocardiogram was noted and the patient underwent emergency coronary angiography which was interpreted as showing a "75 percent proximal left diagonal" obstruction (Figure 2). Because of the persistent chest pain refractory to medical therapy, the physicians at the community hospital performed emergency single vessel coronary artery bypass surgery. He was subsequently transferred to the Long Beach VA Hospital for convalescence. Postoperatively, he continued to complain of chest pain. Further investigation revealed that the patient had never been a commercial airline pilot and that there was no evidence that he had been a prisoner of war in Vietnam.

DISCUSSION

This patient demonstrates many of the characteristics of Munchausen syndrome.¹⁻² The patient gives a history that is detailed and the symptoms are consistent with a recognizable clinical disorder. Secondly, the history is extravagant, but not totally unbelievable. In this case, the patient claimed to be an ex-prisoner of war and an active commercial airline pilot. Third, there is often some objective evidence to support the professed illness. In this case, the electrocardiogram is suggestive of myocardial ischemia or dysfunction. Fourth, the patient is willing to undergo invasive procedures. Fifth, there is a history of numerous visits to different hospitals with similar complaints, yet the patient did not tell any of the hospitals that he had been admitted previously. Sixth, there is a pattern of signing out against medical advice when the patient's demands are not met, or when the patient is confronted with inconsistencies in the history.

Since Asher first described the pattern in a group of patients who went to inordinate lengths to gain admission into hospitals and called it the "Munchausen syndrome," physicians have been perplexed by these interesting and often frustrating patients.³ There is no consensus among psychiatrists as to the motives or psychodynamics of this unusual behavior. The onset of abnormal behavior is triggered by some emotionally traumatic event such as bona fide illness or marital discord. Once the pattern has been established, the patient is compelled to gain hospitalization whenever minor stresses arise in his life. Most such patients present with symptoms of acute abdominal discomfort or neurologic deficit. This patient, presenting with chest pain typical of unstable angina, demonstrates the potential danger of abuse of modern medical therapeutics.⁴⁻⁶

The treatment of this disorder is often unsuccessful. The authors found only one case report of an apparent cure which entailed a lengthy two-

year hospital course during which intensive behavior modification and psychotherapy were used.⁷ Most authors recommend establishing a local registry to help identify such patients and prevent their abuse of hospital systems. An early attempt should be made to verify the patient's history by calling local hospitals and contacting the patient's family.

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FREEMAN-SHELDON SYNDROME WITH UNUSUAL HAND AND FOOT ANOMALIES

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A newborn with the characteristic facies of Freeman-Sheldon syndrome (whistling face syndrome) and unusual hand and foot anomalies is reported. Flexion contractures of fingers were so severe as to prevent their extension. Previously reported patients with similar hand anomalies had only mild to moderate limitation of extension. Over 75 percent

of the 29 previous cases of this syndrome had equinovarus deformity. Not only was this deformity absent but the patient had polysyndactyly of the big toe, an anomaly not previously associated with this syndrome.

Freeman-Sheldon syndrome (cranio-carpo-tarsal dystrophy, whistling face syndrome) is an unusual entity consisting of a characteristic "whistling" face, and hand and foot anomalies.¹⁻¹⁴ The face has deep-set eyes, broad nasal bridge, small nose, long philtrum, and small mouth with protruding lips. Microglossia and high arched palate are typical. Hand anomalies include ulnar deviation of the

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