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Case Report

5 Different Diagnosis for Persistent Vomiting in Early the Infancy Period

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Abstract

The Munchausen syndrome by proxy (MSBP) is fabricating disease either by parents mostly by mother or by caregivers, they were fabricating the symptom because they had social problem or they had mental problem, the victim was always the child or small babies, they exposed them to unnecessarily investigation or treatments. MSBP have different types arrange from mild type which was mild effects to sever types which lead to deaths of babies.

Keywords: *Munchausen Syndrome by Proxy (MSBP); Vomiting; Infancy Period*

Introduction

The Munchausen syndrome is a diagnostically different disease entity. It is a mental disorder consisting on fabricating or causing disease symptoms in other people. It is commonly observed between parent-child relation.

Munchausen syndrome by proxy (MSBP) belongs to factitious disorders. This term gathers diseases in which patient's role is intentionally initiated. MSBP affects child's caregiver, who induces illness in juvenile. However, some authors propose different names to pay attention on child being a victim. Flathery and Macmillan define MSBP as Caregiver fabricated illness (CFI) [1].

MSBP is also more and more commonly named as Medical Child Abuse (MCA) [2].

The term "Munchausen syndrome" was first described in 1951 by Asher [3] to characterize individuals who intentionally produce signs and symptoms of a disease and who tend to seek medical or hospital care. Later, in 1977, Meadow used the term "Munchausen syndrome by proxy" to describe children whose mothers produce histories of illness to their children and who support such histories by fabricated physical signs and symptoms or even by alter laboratory tests [4].

Incidence

The prevalence of Munchausen syndrome is reported to be 0.3% - 0.8%, which is more common in women than in men [5].

The forms of MSBP:

1. Secretive child abuse to induce the symptoms.
2. Fabrication of clinical symptoms.
3. The exaggeration of existing illness [5].

Stage of Manchester by proxy: Radziszewska, Gruszczyński 2010, Jakubowska-Winiecka (2008) listed three stages of MSBP intensification:

- Mild stage: A mother explains fabricated symptoms to medical personnel, child is being unnecessary medically examined. This stage is the easiest to be missed
- Moderate stage: Symptoms are being provoked by a parent
- Severe stage: The most dangerous, mutilation, starvation, poisoning, smothering or other actions which can lead to child's death [5].

Case Report

2-month baby boy Saudi previously healthy, preterm32 weeks SVD, NICU admission for 19 days due to RDS, discharged in a good condition.

Now Presented to ER c/o vomiting for 2 days and fever for 1 day.

Vomiting for 6 times were after feeding of food content not projectile, bloody, or greenish. Fever associated with decrease activity and oral intake.

Systemic review

No history of abnormal movement. Breathless, sweating during feeding, cyanosis, jaundice, diarrhea, blood/mucus in stool, change in stool color and no history of rash, or itching.

Preterm, 32 weeks NICU admission for 19 days due to RD birth weight: 1.8 kg. Vaccination and developmental Up to his age feeding bottle feeding since birth, now 60 ml every 3 hours. Family history negative consanguinity and no similar condition in the family.

Summary

2-month-old baby boy presented with 2 days history of vomiting and decrease of activity. History of fever for 1 day.

So, the initial impression was:

1. Sepsis to R/O CNS infection.
2. Hidden infection? (UTI).

On examination

Generally: Patient looks well conscious, no dysmorphic features, anterior fontanels was normal.

Vitals: T: 37 HR: 130 ppm, O_2SAT: 100%, RBS: 78 mg/dl.

Weight: 2.9 kg on 5th centile.

Chest: good breath sound bilateral.

Abdomen: soft, Not tender, no Organomegaly.

CVS: S1+S2+0 NO added sound.

CNS: Normal tone, power and reflexes.

Investigation

WBC: 13.6 mainly lymphocyte: 59.6%.

Eosinophil's counts was 16%, HGB = 8.2, PLT = 469.

ESR = 15, CRP 0.2.

Renal, hepatic and bone profiles and electrolyte were normal.

Blood culture and urine culture were negative, lumbar puncture was refused by the family.

So, the initial impression was: sepsis, UTI, cow milk protein allergy.

Hospital course

Patient was started on anti-biotic cefotaxime and ampicillin, kept NPO initially then in subsequent days started on hydrolyzed formula on the assumption of cow's milk protein allergy as his eosinophil's count was high, baby started to improve, fever subside, taking orally well, blood and urine culture were negative, where after 7 days both antibiotic stopped. However, patient remained suffering from vomiting after each feed the same milk which was ingested and was not bloody or bilious. Examination revealed well looking child and his systemic examination were normal. At the same time ultrasound abdomen done, showed normal finding and there is no evidence of pyloric stenosis, but barium studies showed significant gastro esophageal reflux. Here baby started on anti-reflux measures upright position with frequent small feeds every 2 hours with a hydrolyzed formula - and added motilium and omeprazole. However, in subsequent days baby still vomiting after each feed, most of the amount.

Here the plain abdominal x-ray and barium studies revised by an expert radiologist and report that this barium study is showing stomach malrotation, so the pediatric surgeon was consulted and suggested a conservative measure to treat stomach malrotation. Patient started on continuous NGT feeding of a hydrolyzed formula in a semi sitting position in escalating manner very gradually with 5cc per hour per day. Once we reach 15 - 20 ml mother complaining that her child start to vomit again after each feed. where a surgeon decided to operate and correct the defect of malrotation in the subsequent days.

During these coming days prior to operation, the baby was observed meticulously for his feeds and was noticed on three occasions by our team that he is able to take his feeds up to 40 ml every 2 hours to meet his required need efficiently, without vomiting. So it was very clear that this mother was misleading the treating group by fabricating the symptom of vomiting although this baby was suffering initially from sepsis, then GERD then, cow's milk allergy then malrotation of the stomach and all these possibities was documented and dealt with adequately and correctly.

However, after reviewing the case and took more history from the ant, the following information was very important to justify the final decision.

Which was taken by the primary treating pediatrician who ask to hold the operation mainly because of the following factors patient was noticed to thrive well as his admitting weight was 2.9 kg verses the current weight is 4 kg, the feeds which was witnessed by the team and was smooth without any problem, a mother who never ask for discharge all through her stay in the hospital for two months, the father who never appear except at time of a consent for the operation. Digging more in the social background, revealed that this mother is 37 years old, very buzzy as she got total of 14 children, however she was so happy to stay in the hospital gathering with other mothers at after noon and night for fun and interest away from the stressful home environment, her teenager sun 16 years old escaped from home with his friends where his father blame the mother for this event and was about to divorce her. But his ant spent a great effort to retain him back home. So it was clear because of all these factors, mother was trying to stay in hospital away from all these stressful affairs, by fabricating this symptoms of vomiting, although we confirmed a series of different diagnoses starting with cow's milk protein allergy, GEARD, stomach malrotation which were a real ones however we end up with a final diagnosis of Munchhausen by proxy syndrome.

This patient was discharged after convincing the mother that her son is doing very well as well as growing very well, then the baby was seen as an outpatient 2 weeks and then 2 months after discharge where his weight was 5,6 kg and generally he is doing very well.

So patient was discharged safely from the clinic.

Discussion

The Munchausen syndrome is a mental disorder consisting on fabricating or causing disease symptoms in other people. It needs to sit-down with persons who have this disease and it is multidisciplinary, need doctors, nurses, psychiatric, parents and social workers to discuss with him/her why she/he did that and informed her/him this dangerous disease, it was consumed time and efforts and exposed the child to unnecessarily investigation.

And the person who had this disease must be treated and follow up with psychiatric doctor to look for the cause. we must inform social worker to come and sit with this person to know what is the background? Why he/she did that? And referred him to clinic if necessarily.

The child who was exposed to this type of harm must be protected socially and had frequent visit to home to observe him very closed.

If child admitted to the hospital many times with different complain we must take full history and social history to roll out MSBP.

The education is very important, in our case social worker had to stay with parents and explained to them, and tried to help them by different methods and explained to them the fabrication of symptom will expose their child to harmful investigation.

The child who exposed to MSBP must be careful follow up in OPD.

Conclusion

We have proposed a treatment protocol for families in which the parent has engaged in MBP abuse. Cases studies and considerable clinical experience reveal that abusers who have been able to genuinely acknowledge the abuse, have effective family support, and are able to experience remorse and empathy for their victim(s) are most likely to benefit from treatment. While extremely difficult to conduct, formal treatment outcome studies would allow for more robust data related to treatment effectiveness and potentially allow for refinement of the protocol. At a larger level, there remains an urgent need for greater awareness, training of legal and CPS personnel, and access to qualified clinicians to assist these families.

Conflict of Interest

Dr: Mohammad Fattani declare that they have no conflict of interest.

Compliance with Ethical Standards

Human and Animal Rights: No human or animal research was conducted by the authors for this literature review.

Informed Consent

This paper did not include the collection or analysis of data. Accordingly, there is no requirement for review.

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