ABSTRACT
A gentleman in his mid-thirties presented with an interesting history of multiple medical problems including Haemophilia B, intracerebral haemorrhage and renal transplantation for chronic renal failure. While in hospital, he constantly requested for analgesia. When he was refused, he stalked off angrily. A review of his medical records showed that none of the events described in his story were true. He had been to many other hospitals with different stories in order to receive treatment. The patient displayed the classical features of chronic factitious disorder with physical signs and symptoms, also known as Munchausen syndrome.

KEYWORDS: Munchausen Syndrome, Chronic Factitious Disorder.

INTRODUCTION
Munchausen syndrome is a psychiatric disorder wherein those affected feign disease, illness, or psychological trauma to draw attention, sympathy, reassurance to themselves. Also known as hospital hopper syndrome, hospital addiction syndrome, thick chart syndrome, true Munchausen syndrome fits within the subclass of factitious disorder with predominant physical signs and symptoms. Factitious disorders are displayed by patients who actively seek to assume the side role, without obvious secondary gains from feigning illness. If they...
do display ulterior motives, the disorder would most likely be termed malingering. The popular name for this factitious disorders with physical disorders has become Munchausen syndrome-named so after German officer Frieherr Von Munchausen. With this disorder there is a need to remain in the sick role, and these patients are often hospitalized multiple times for the feigned illness.[2]

CASE PRESENTATION
A 34 year old Indian male was presented with complaints of severe headache. In addition, to a long standing history of migraine, Haemophilia B, and chronic renal failure secondary to gout. He had recently also undergone a CT scan in which he said had shown an intracerebral haemorrhage. Furthermore, as treatment for his renal failure, he claimed that he had undergone two renal transplants in Delhi in 2001 and 2010, with the first being unsuccessful. This, he said, was why he had a scar at his left loin area. He demonstrated good knowledge of the names of nephrologists and urologists in hospital and he was able to detail his drug treatment as being allopurinol, prednisolone and cyclosporine. As for his social history, he claimed to be a long distance lorry driver. He explained that he often had to break journey to seek treatment for his recurring headaches for which he produced documents from two other hospitals where he had received his treatment before. Before any medication could be given to him, he cautioned the doctor that he was allergic to most conventional analgesics, particularly the non steroidal anti-inflammatory drugs. He also displayed a hospital letter which said he was ‘apparently allergic to anticholinergics.’ One of the analgesics that he claimed that he was able to tolerate was pethidine, but in view of Haemophilia B, he advised the doctor to administer it intravenously and not intramuscular. Nonetheless, despite being given two doses of 100 mg intravenous pethidine over the space of 6 hours, he still complained of severe headache and demanded further analgesia from the staff. His case was then reviewed by a more senior doctor who found no evidence of transplanted kidney in the iliac fossa. When challenged about this, the patient glibly answered that he had haemophilia B and thus had required a different procedure. The patient was offered alternative forms of analgesia instead but he became angry and threatened to call the head of the surgical unit. Nonetheless, the medical staff did not relent and the patient then took his own discharge against medical advice.

The story did not end there however. In the following week, we were informed that the patient had been seen again once in other hospital and had requested intravenous pethidine.
for renal colic. A search for his past medical records revealed that there had been at least three other occasions when he, under various guises had told similar tales to gain hospital admission. Finally an enquiry with the renal staff of hospital solved the issue. The patient had genuinely suffered from renal calculi and colic previously, but this had resolved with treatment. Nonetheless, he continued to demand medical attention at the hospital even though all the radiological and other invasive investigations during his multiple admissions did not show any recurrence. He had been admitted under the heamatological unit under the guise of having a blood dyscrasia. However, none of the history concerning the renal transplants, haemophilia and intracerebral haemorrhage was true. In fact, what the patient actually had was Munchausen Syndrome.

**DISCUSSION**

Munchausen syndrome is relatively new diseases with the first description by Asher.[3] Among the features mentioned was the patient’s presentation with apparent acute illness, supported by a plausible or dramatic history. These patients had attended and deceived an astounding number of hospitals and they nearly always discharged themselves against advice after quarreling violently with the doctors. Asher’s description of the syndrome was based on the Raspe’s writings concerning the 18th century army officer Baron Munchausen. As with our patient, Baron was widely travelled and he was renowned for the untrue tales that he told of his adventures.

Under the more recent DSM –IV criteria, Munchausen syndrome would be considered as a chronic factitious disorder with physical signs and symptoms. DSM –IV listed a number of features that were found impatient with such factitious disorders.[4] Such patients often gave histories with dramatic flair and pathological lying in a manner that fascinates the listener (pseudologia fantastica). They also showed extensive knowledge of medical terminology and medical routines. Complaints of pain and requests for analgesics were also common. When confronted, the patients would deny the allegations or rapidly take their own discharge, only to show up at another hospital soon after, possibly under a different name or address. These features are all well illustrated in our case.

The etiology of Munchausen syndrome is not well established. As in our patient, some cases have genuinely had medical therapy for an organic illness before and this may have let them to become dependent on the safe environment of a hospital.[5] Childhood deprivation and antisocial personality traits may be associated features. Wherever possible, patients should be
referred for psychiatric consultation. However successful therapy for patients with Munchausen syndrome is extremely difficult given their penchant for wandering and taking their own discharge when confronted. As such, early recognition is crucial in order to avoid time and expenditure being wasted on potentially harmful investigations and treatments in these willing patients.

**CONCLUSION**

However successful therapy for patients with Munchausen syndrome is extremely difficult given their penchant for wandering and taking their own discharge when confronted. As such, early recognition is crucial in order to avoid time and expenditure being wasted on potentially harmful investigations and treatments in these willing patients.

**REFERENCES**