

determine if anti-gangliosides antibodies are more frequently present in axonal polyneuritis following *Campylobacter* infection than in the typical Guillain-Barré syndrome, where the frequency of such antibodies is 19%.³

From Service de Neurologie, Centre Interuniversitaire Ambroise-Paré, Mons, Belgium.

Received April 1, 1991. Accepted for publication in final form May 30, 1991.

Address correspondence and reprint requests to Dr. A.G. Herbaut, Service de Neurologie, Hôpital Erasme, Route de Lennik, 808, 1070 Bruxelles, Belgium.

References

1. Yuki N, Yoshino H, Sato S, Miyatake T. Acute axonal polyneuropathy associated with anti-GM₁ antibodies following *Campylobacter* enteritis. *Neurology* 1990;40:1900-1902.
2. Kaldor J, Speed BR. Guillain-Barré syndrome and *Campylobacter jejuni*: a serological study. *Br Med J* 1984;288:1867-1870.
3. Ilyas AA, Willison HJ, Quarles RH, et al. Serum antibodies to gangliosides in Guillain-Barré syndrome. *Ann Neurol* 1988;23:440-447.

Factitious status epilepticus as a particular form of Munchausen's syndrome

Richard C. Christensen, MD, and Jerzy W. Szlabowicz, MD

Factitious disorder with physical symptoms is defined as intentional production or feigning of physical complaints for the primary purpose of assuming the patient role.¹ The medical presentations of these disorders are diverse.²

Munchausen's syndrome is a particular type of factitious disorder encompassing a subset of patients who demonstrate sociopathic traits such as pathologic lying, impostership, and a pervasive commitment to the patient role.³ Although there are many neurologic manifestations of Munchausen's syndrome reported in the literature, we found only one example of Munchausen's syndrome presenting as status epilepticus.⁴ We report a second such patient.

Case report. A 33-year-old man was transferred from a short-term crisis stabilization unit where he had been held after being evaluated for suicidal threats. At one point during the 7-day period in which he had been at that facility, he had been rushed by ambulance to a local hospital in status epilepticus, admitted, and treated with large doses of parenteral and oral anticonvulsants.

Upon admission to our hospital, he was responsive and alert, though somewhat dramatic in detailing a history of chronic drug and alcohol dependence spanning 13 years. In addition, he reported numerous hospitalizations for a seizure disorder that was poorly controlled on his current multiple anticonvulsant regimen consisting of phenytoin, phenobarbital, valproic acid, and carbamazepine. The nature of his seizure disorder, he said, was well documented in records located in an out-of-state hospital. His examination was significant for numerous well-healed, transverse scars covering the ventral aspects of both forearms as well as fresh, superficial lacerations on his left arm and neck.

Approximately 60 minutes following admission, the patient was observed to fall backward from his chair while sitting in the patient recreation area, land on his elbows, and assume a supine position. He was unresponsive to name or commands, and his eyes were tightly closed. Pupils were equal, round, and reactive.

Jerking, semirhythmic movements of the upper and lower extremities were observed to last from 20 to 30 seconds and occurred every 60 seconds. Pulse rate increased, but respirations were stable and no cyanosis was noted. The facility's status epilepticus team was notified and arrived within the first 10 minutes of the convulsive activity. Repeated attempts to gain IV access were unsuccessful until a left femoral catheter was introduced. Ten mg of diazepam was given, but the patient continued to exhibit seizure-like activity and was transferred to the intensive care unit. All further medications were held and an EEG was obtained, which revealed movement artifact during apparent clonic seizures, but no epileptiform focus. In addition,

no interictal abnormalities were noted. Arterial blood gases drawn after approximately 40 minutes of convulsive activity were normal. A prolactin level, which was subsequently compared to the patient's baseline, was normal. The convulsive activity ceased after 50 minutes and the patient became responsive to name and commands. A postictal EEG was normal. A diagnosis of pseudoseizures was made at that time.

When the patient's parents were contacted, it was learned that the patient had worked very little during his adult life and had spent the better part of the past 10 years traveling from hospital to hospital. According to his mother, the patient's frequent hospitalizations for his alleged seizure disorder had resulted in a debt to the family that had exceeded \$40,000. She confirmed that multiple evaluations had failed to identify a seizure disorder and she denied that her son had a history of drug dependence. Records obtained on the patient documented numerous intensive-care-unit admissions for status epilepticus, resulting in the administration of large doses of multiple parenteral and oral anticonvulsants. However, even though neurologic evaluations were negative, with EEGs that revealed no epileptiform focus or interictal/postictal abnormalities, it was nowhere documented that the possibility of a factitious disorder was a diagnostic consideration in this patient. He was routinely discharged from various facilities on large doses of anticonvulsant medications only to return to a different emergency room exhibiting symptoms consistent with an uncontrolled seizure disorder.

When the patient was confronted with these findings, he admitted that he deliberately feigned symptoms in order to gain entry into hospitals. He stated that over the course of the past 13 years he had traveled to over 50 emergency rooms in two states to be evaluated for numerous complaints. It had been, however, only in the past 2 years that he exhibited symptoms mimicking status epilepticus. When the patient was not in a hospital, he lived at home with his parents, whom he described as "religious evangelists" and rigid disciplinarians. Although he was quite unhappy with the living arrangement, he saw few alternatives, since he had developed no means to support himself over the years. As a consequence, when he became anxious or depressed about his life situation, his increased need to seek medical attention for various factitious complaints would lead him to numerous emergency rooms.

During the course of the patient's psychiatric hospitalization, he was weaned completely from his anticonvulsant medication. He demonstrated no further seizure activity or self-mutilating behavior and frequently stated that he was relieved and determined to put an end to his self-destructive lifestyle. Psychological testing revealed findings strongly supportive of borderline and antisocial personality traits. Outpatient psychotherapy on a weekly basis was arranged prior to discharge. The patient returned to his parents' home and is currently working on a full-time basis. In the 2 months since discharge, he had not sought hospitalization.

Discussion. The classic Munchausen's syndrome, as described by Asher in 1951,⁵ is characterized by factitious illness (ie, self-inflicted or feigned), peregrination (ie, wandering), pseudologia fantastica (ie, extraordinary fabricated tales), and dramatic symptomatology. Our case is a form of Munchausen's syndrome but is unusual because of the factitious status epilepticus. The patient's long history of factitious complaints requiring medical attention, his wandering to over 50 emergency rooms in the span of 13 years, as well as the theatrical manner in which he focused attention upon his clinical presentation all support the diagnosis of Munchausen's syndrome. Although the psychogenesis of Munchausen's syndrome is unclear, it may result from the interplay between personality factors and psychosocial stressors. Because many of these patients evidence borderline personality disorders, their demanding, impulsive, and self-destructive natures allow them to switch emphasis from one set of symptoms to another depending on the circumstances.⁶ Our patient's pattern of hospitalization appeared to be linked to psychosocial stressors. Events or incidents that would elicit anger, anxiety, or depression were likely to trigger his pathologic care-seeking behavior, which probably arose out of a desire for attachment taken to grotesque extreme. However, it is not clear why he chose to feign episodes of status epilepticus after so many years of simulating other complaints.

There are some therapists who believe the disorder is untreatable,³ while others hold the view that the only workable therapeutic option is long-term psychotherapy and complete abandonment of the pathologic lifestyle.⁷ However, because Munchausen patients risk personal and social disintegration, health care providers endure frustration

and dismay, and families and institutions incur enormous expenses for the provision of unneeded medications and procedures, it is critical that such patients be properly diagnosed and given the opportunity to alter their behaviors.

From the Inpatient Psychiatry Unit, Gainesville VA Medical Center, Gainesville, FL.

Received May 29, 1991. Accepted for publication in final form May 30, 1991.

Address correspondence and reprint requests to Dr. Jerzy W. Szlabowicz, Assistant Professor in Psychiatry, Box J-256, JHMHC, University of Florida, Gainesville, FL 32610.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd rev. ed. Washington, DC: American Psychiatric Association, 1987:315-320.
2. Sutherland AJ, Rodin GM. Factitious disorders in a general hospital setting: clinical features and a review of the literature. *Psychosomatics* 1990;31:392-399.
3. Eisendrath SJ. Factitious physical disorders: treatment without confrontation. *Psychosomatics* 1989;30:383-387.
4. Savard G, Andermann F, Teitelbaum J, Lehmann H. Epileptic Munchausen's syndrome: a form of pseudoseizures distinct from hysteria and malingering. *Neurology* 1988;38:1628-1629.
5. Asher R. Munchausen's syndrome. *Lancet* 1951;1:339-341.
6. Nickoloff SE, Neppe VM, Ries RK. Factitious AIDS. *Psychosomatics* 1989;30:342-345.
7. Schlesinger RD, Daniel DG, Rabin P, Jack R. Factitious disorder with physical manifestations: pitfalls of diagnosis and management. *South Med J* 1989;82:210-214. ■

Neurology®

Factitious status epilepticus as a particular form of Munchausen's syndrome

Richard C. Christensen and Jerzy W. Szlabowicz

Neurology 1991;41;2009

DOI 10.1212/WNL.41.12.2009

This information is current as of December 1, 1991

Updated Information & Services

including high resolution figures, can be found at:
<http://n.neurology.org/content/41/12/2009.citation.full>

Permissions & Licensing

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
http://www.neurology.org/about/about_the_journal#permissions

Reprints

Information about ordering reprints can be found online:
<http://n.neurology.org/subscribers/advertise>

Neurology® is the official journal of the American Academy of Neurology. Published continuously since 1951, it is now a weekly with 48 issues per year. Copyright © 1991 by Edgell Communications, Inc.. All rights reserved. Print ISSN: 0028-3878. Online ISSN: 1526-632X.

