Migratory exploratory laparotomy is one of the four types of psychosomatic disorders referred to as Münchhausen’s Syndrome. Patients manifest symptoms of acute abdominal cavity disease. Thus, numerous diagnostic examinations are required, the results of which rarely produce a clear diagnosis. The surgeon, who during the course of his practice comes across patients suffering from the above-mentioned type of disorder, is often faced with the difficult decision of whether or not a exploratory laparotomy should be performed. The reasons behind the development of Münchhausen’s Syndrome, which may be clarified by following a detailed patient history, will perhaps help to avoid unnecessary laparotomy.

Key words: migratory laparotomy, simulation, psychosomatic disorders

Münchhausen’s Syndrome (1) is a rarely diagnosed disease entity in clinical practice, and data concerning the issue are rather scarce. It is widely accepted that 30-50% of patients visiting physicians complain of somatic symptoms, the origin of which cannot be attributed to any organic disease on the basis of available diagnostic examinations (2).

The current literature presents more and more publications describing the etiology, symptoms, possibilities of early diagnosis and therapy concerning Münchhausen’s Syndrome. This disease entity is classified as one of many somatomorphic diseases. According to the ICD-10 classification, Münchhausen’s Syndrome was ranked in the section of psychotic and behavior disturbances as deliberate simulation of physical and psychic symptoms, the so-called feigned disturbances (3).

Münchhausen’s Syndrome consists in long-lasting simulation or creation of disease symptoms, often of credible impression. The origin of the syndrome is connected with intensified emotional conflicts, which coexist with personality disturbances, and their improper relationship with the patient’s environment (4, 8).

The simulation of symptoms is conscious, although the motives remain unknown. The development of the above-mentioned disturbances is closely connected with inadequate reactions towards stressful situations. Münchhausen’s Syndrome is an example of a somatic disorder resulting from neurotic conditioning. The simulation of symptoms is aimed at obtaining medical care, diagnostics or therapy. The patient is unable to take control over repeated and impulsive simulation of disease symptoms (5).

Münchhausen’s Syndrome was first described by Richard Asher in the The Lancet in February, 1951 (1). The author of the article presented three cases with abdominal symptoms of the disease. These patients were hospitalized many times due to acute abdominal symptoms. The accounts of the symptoms were so suggestive and credible that consecutive physicians were misled. Patients were subjected to diagnostics and operation when there was suspicion of intestinal obstruction. Consecutive exploratory laparotomies did not confirm the initial diagnosis (1). Asher described the presented cases as Münchhausen’s Syndrome. The
name of the syndrome relates to the adventures of baron Karl Friedrich Hieronymus von Münchhausen (1720-1797), described by R.E. Rasp, which was first published in Oxford in 1785 (6). Baron von Münchhausen became famous for his numerous unbelievable, colorful, devised and often exaggerated adventures (7).

Patients with Münchhausen’s Syndrome present with the exaggerated desire to draw attention to themselves in order to obtain medical care. The disease is manifested by the presentation of diverse and often bizarre symptoms. Patients with the syndrome often mention symptoms in detail, as well as operations that they underwent. These stories usually raise no doubts. On the contrary, they evoke interest and sympathy. Münchhausen’s Syndrome patients are easily subjected to diverse examinations and surgical procedures. They reluctantly agree to psychiatric evaluation, and leave the hospital in case of such danger. Patients with Münchhausen’s Syndrome often wander from hospital to hospital, selecting the facility with the most attractive location. They usually arrive at the emergency room in the afternoon or as emergency cases (9).

Symptoms presented by patients with Münchhausen’s Syndrome can be divided into several types (1, 3):

1. Abdominal type – migratory laparotomy.
   Surgery is usually performed following suspicion of mechanical ileus. Symptoms of appendicitis, cholecystitis or nephrolithiasis are rare causes of hospital admissions. Patients with this type of Münchhausen’s Syndrome usually have a significant history of surgical department hospitalizations and numerous abdominal operation scars.

2. Hemorrhagic type – hemorrhagic hysteria (merchants hematomesis). These patients present with gastrointestinal or respiratory tract bleeding, or symptoms of hemophilia. Patients cause nose bleeding or swallow animal blood in order to imitate gastrointestinal hemorrhage.


4. MBPS (Münchhausen By-Proxy Syndrome).
   This syndrome is a form of child tormenting by their caregiver, mostly mothers. It consists in the evocation or mentioning of disease symptoms, as to draw attention and underline the commitment of the caregivers in the care of children.

CASE REPORT

B.M., a 34-year old female patient (history number – 25777/05) was admitted to the hospital on 8.12.2005 with suspicion of intestinal colic. On admission the patient complained of acute, diffuse and continuous abdominal pain, cholemesis, constipation and gas retention. Symptoms developed several hours before when travelling by train. The patient was hospitalized at one of the Surgical Departments in Warsaw during the period between 24.11-2.12.2005 with suspicion of gastrointestinal perforation. She underwent exploratory laparotomy, which showed no abnormalities. The patient was discharged from the hospital in good general condition.

Historical data revealed that the abdominal symptoms developed after a road accident that took the lives of her parents and brother. Since 1999, the patient had been hospitalized many times in surgical departments. She underwent eight abdominal operations.

The physical examination was as follows: heart rate – 80/min, arterial pressure – 110/60 mmHg, and body temperature – 36.8°C. She appeared to be in pain with her feet tucked up, while lying on her back. The physical examination revealed numerous abdominal scars, flatulence, pain on palpation and increased muscle tone. Peritoneal symptoms were absent with hypoperistalsis.

Lab results demonstrated decreased hematocrit, RBC, and calcium levels, as well as hyperchloremia and hyperphosphatemia. Both the contrast X-ray and ultrasound examinations showed no abnormalities.

The patient received conservative treatment including continuous epidural anesthesia, sedatives and bowel movement stimulants. Her general condition improved with normal defecation.

The psychiatric consultation demonstrated mood depression without suicidal thoughts, and the proposition of psychiatric observation. On 12.12.2005, the patient was discharged from the hospital at her own request.

She was once again admitted to the hospital on 18.01.2006 (history number 1311/06) with similar symptoms as previously reported. Detailed diagnostics showed no abnormalities of the upper digestive tract. Contrast enema
showed no mechanical obstruction, while ultrasonography and CT examinations demonstrated no abdominal cavity pathologies (except for hepatomegaly). Additionally, rectoscopy and incomplete colonoscopy (lack of cooperation) performed twice demonstrated no pathologies.

The patient received similar therapy as in her previous admittance, although exploratory laparotomy was not performed. After several days the patient was discharged from the Department of Internal Medicine at her own request in good general condition. One week after discharge from our hospital we received notice that the patient was twice under observation in other surgical departments. According to information obtained from her caregiver, she was without symptoms until November 2006, as she was on psychiatric medication.

DISCUSSION

Considering the presented case report, diagnosis was established after detailed diagnostics and hospitalizations at the Departments of Surgery, Internal Medicine and Psychiatry. When establishing the diagnosis, the course of the disease and history data were considered. First symptoms developed in 1994. The patient was hospitalized 17 times during the period between 1994 and 2006 in hospitals throughout the country. The cause of hospitalization was as follows: acute abdominal pain of unknown etiology, suspicion of upper digestive tract bleeding, porphyria, ovarian cyst torsion, mechanical ileus, gastrointestinal perforation, as well as non-specific intestinal inflammatory diseases. The patient underwent exploratory laparotomy eight times. Indications towards laparotomy included suspicion of intestinal obstruction and symptoms of peritonitis. Only twice were organic lesions observed in the peritoneum. In the first case, there were adhesions between the intestinal loops, and in the second case the intestinal loop was necrotic due to strangulation. The remaining operations demonstrated no abdominal pathologies, apart from intestinal adhesions, of clinical insignificance.

Conservative treatment and sedatives led towards the regression of symptoms, which enabled us to perform detailed gastrointestinal tract diagnostics, as well as the psychiatric consultation. Proper diagnosis enabled us to avoid exploratory laparotomy during consecutive hospitalizations.

CONCLUSIONS

Münchhausen’s Syndrome is a rarely diagnosed disease entity, which might pose difficulties when establishing diagnosis. The collection of detailed patient history data with coexisting symptoms, accompanied by normal examination results should arouse suspicion of the above-mentioned syndrome. Only the precise analysis of obtained results will enable us to avoid unnecessary operations.

REFERENCES


Received: 18.09.2007 r.
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