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Research Article

The Prevalence of Munchausen Syndrome in Vilnius

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ABSTRACT

Background: Although the Munchausen Syndrome (MS) are already known for 70 years, most of the studies are only literature reviews and clinical cases. Prevalence of this syndrome increases confusion in the team of health care professionals, complicates somatic diseases doctors daily work and also wastes doctors' time and energy as well as institution's financial resources. The reason of this problem could be the lack of knowledge of healthcare professionals how to deal with such disorders. The aim of this study is to find out the prevalence of MS in the city of Vilnius and to compare the results with literature, also to clarify the difficulties that we have because of this syndrome in the capital and to provide practical recommendations for solving them.

Methods: The pilot research was done. A non- validated questionnaire for doctors was conducted in 17 different Vilnius medical institutions.

Results: A total of 358 doctors from 17 treatment facilities were interviewed. The majority of respondents were family doctors 166 (46%) and pediatricians 82 (23%). 358 (10.9%) of the capital's doctors reported 669 patients with MS. Most doctors 222 (80.43%) knew about MS and 77 (93.90%) pediatricians knew about Munchausen Syndrome by proxy (MSBP) before survey. 108 (90%) doctors recommended psychiatric consultation. 50 (60.98%) pediatricians did not recommend psychiatric consultation.

Conclusions: The prevalence of Munchausen Syndrome in Vilnius is 1.12%. Most doctors in the city of Vilnius know Munchausen's Syndrome. Most doctors do not offer psychiatric counseling to suspected MS patients.

Keywords: Munchausen Syndrome, Munchausen Syndrome by proxy, prevalence.

Introduction

The Munchausen Syndrome (MS), also called factitious disorder imposed of self (FDIS), is a falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception. The individual presents himself or herself to others as ill, impaired, or injured. The deceptive behavior is evident even in the absence of obvious external rewards. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder. The Munchausen Syndrome can also be factitious disorder imposed on another (FDIA). Then the individual presents another individual (victim) to others as ill, impaired, or injured [1]. In these diseases, the physical symptoms are deliberately caused or factitious to create a "sick patient" image. The objective condition and tests result of these patients do not correspond to the symptoms they indicate. Prevalence of this syndrome increases confusion in the team of health care professionals, complicates somatic diseases doctors daily work and also wastes doctors' time and energy as well as institution's financial resources. Moreover, the "somatic" condition and well-being of such patients, despite doctors' attention, studies and tests, are not improving [2,3].

Epidemiology

Studies in primary medical care of unexplained medical complaints suggest that 30-64% of all patient-initiated visits are for medical complaints with no identifiable physical cause [4]. It is difficult to determine the exact prevalence of MS because it is difficult for doctors to recognise and confirm the diagnosis. In addition, prevalence is difficult to estimate due to limitations in methodological research such as the type of the study (survey of doctors or analysis of the demographic database), populations (general practitioners or specialist doctors), places (hospital department, clinic, disability service), duration, size of the sample to be examined. It is important to note that a large proportion of people with MS do not go to medical institutions but play a role in the family, at work, with friends, on websites and are not included in medical epidemiological assessments. Online support groups create great conditions for patients with MS to get a lot of attention because they can create a false identity and can get a lot of compassion from a large audience [5].

Although methodological problems make it difficult to estimate the actual prevalence of MS and MSBP, it is estimated that people with MS are between 1% and 1.3% of hospital admission [5,6]. In clinical research via retrospective chart

reviews, Krahn, Li and O'Connor identified 93 occurrences of FDIS over 20-year period in general medical inpatient population. They found that FDIS had been included as an official discharge diagnosis in only 20 of these cases [7]. Also, prevalence rates of FDIS appear to be higher for patients with borderline personality disorder [8], which may be taken as evidence for an association between these two diagnoses. Moreover, Fliege and colleagues surveyed 83 physicians, who observed FDIS in 1.3% of their patients, though the range of estimates was very wide [9]. Also, in a compeling but seldom cited study, Sansone, Weiderman and Mehnert-Kay asked primary care patients to complete a condifential questionaire related to medical self – sabotage; 6.6% of patients admitted to actively and intentionaly causing, prolonging or exacerbating an ilness [10].

The prevalence of MSBP is between 2-2,8 / 100,000 children under 1-year age and 0.4 / 100,000 children age from 1 to 16 years. The mean age of children in establishing MSBP is between 14.9 and 21.8 months, their mortality is between 6% and 10% and more than 33% when parents use their force (suffocation, poisoning) [6,11].

Most patients who have a suspected MS deny diagnosis and even become hostile. Often the patient refuses the services of a medical institution and goes to another hospital. The identification of MS and MSBP is supported by certain risk factors presented in Table 1 and 2 [5].

Etiology

The etiology of the disease is unknown, but certain psychosocial factors are evident in patients with MS. According to Reich and Gottfried, difficult childhood (sexual harassment, parental carelessness, loss of a loved one in youth) is one of the main factors in the emergence of MS [12]. It is believed that people cause their sickness to get an attention and care from hospital staff that they do not get at home. A small group of these patients who admit to having this disorder claim that the main reason for this behaviour is to feel that you are important and that someone cares for you [2]. It is also believed that some patients are being flooded by an "adrenaline rush" from their medical procedures and the feeling that they can manage health care professionals [3]. In addition, Yates and Feldman have analysed other psychiatric disorders such as mild depression in 170 cases after analysing 455 clinical cases of MS [13]. Comorbidity between mental disorders and MS was 80% [14]. Unfortunately, the exact etiology of MS is still unknown.

Table 1: Common features of MS patients [5].

Women
Working in a health care institution
Middle age (35-50)
Not married
Diagnosed with depression

Table 2: General human features of MSBP [5].

Women (usually victim's mother)
Sexual harassment during childhood
Personality disorders
Lack of support from partner / divorce
Often good education
Rarely leaves a child / victim unattended
Formes close relationships with hospital staff

Clinical symptoms

Most patients have somatic complaints. Although MS can be very diverse, it is noted that most people complain of chest, abdominal pain, vomiting and / or diarrhoea, anaemia, hypoglycaemia, infections, seizures, skin lesions, arthralgia [2] and other symptoms listed in Table 3 [15]. Often, patients cause these symptoms in various ways - eating a faulty food, injecting insulin, scratching the skin, overdosing or not taking any medicine. In addition, patients are falsifying medical records and laboratory tests [2].

Diagnostics

MS and MSBP are easier to diagnose using ICD-10 and DSM-5 classification criteria [1,16] and information from Table 2 and 3 in oder to identify common features of these disorders. Most often, MS starts at an early age. There is an atypical expression of the disease - the clinical examination does not match the laboratory results and instrumental research. Also, suspicion of MS can occur when a major medical history with unsuccessful treatment is observed, many visited medical facilities and the patient using a lot of medical terminology in his or her speech showing his / her medical knowledge [6]. There are some warning signs also called "red flags" that can help doctors suspect MS. They are listed in Table 4 [5]. In order to make it easier to imagine how a patient with MS might look like, Table 5 and 6 describe 2 clinical cases shared by the capital's doctors. There are also some warning signs that can helps doctors suspect MSBP. They are listed in Table 7 [14]. To make it easier to imagine how a patient with MS by proxy might look, Table 8 shows a clinical case shared by a Vilnius city doctor.

Objective of study

1. Evaluate the prevalence of the Munchhausen Syndrome in the city of Vilnius.
2. To compare the results obtained with the literature to identify the difficulties that arise with this disorder in Vilnius and to provide practical recommendations for solving the problems.

Methods of the study

The pilot research was done. A non- validated questionnaire for doctors was conducted in 17 different Vilnius polyclinins and hospitals. For that reason, psychometric properties of the questionnaire have not been measured. All polyclinics and hospital administrations received permission to conduct a medical survey. Examples of questionnaires (1 for MS, 2 adapted for pediatric MSBP) are given in Annexes 1 and 2. If the medical institution was allowed to do so - before the interview, doctors were given a message about the Munchausen

Table 3: Most common MS complaints and symptoms [15].
Gastrointestinal: abdominal pain, vomiting, haematemesis
Lung: blood cough, shortness of breath, symptoms of pulmonary embolism
Heart: chest pain and palpitations
Neurological: pseudo-seizures, short-term ischemic attacks, unexplained weakness
Endocrinological: hypoglycaemia (caused by exogenous insulin) and hypothyroidism (exogenous thyroxine)
Nephrological: kidney colic and hematuria
Infectious: bacteremia (from injected feces), fever (heats the thermometer on purpose, drinks hot drinks, uses pyrogenic substances (eg.: vaccines, hormones)), urinary tract infections (stools into urine)
Musculoskeletal: self-inflicted injuries, wounds
Hematologic: anaemia (low blood pressure) and mild bleeding (using exogenous anticoagulants)

Table 4: MS Clinical Warning Signs [5].
Atypical symptoms
Ineffective treatment of symptoms
Allergy to many medicines
Only a few visitors during hospitalisation
New symptoms help to reduce existing symptoms
The broad history of the disease does not match the results of diagnoses and medical interventions

Table 5: 1st clinical case
60 years old woman. The first patient's document saved in the hospital database was in 2005. The woman underwent esophagogastroduodenoscopy. Conclusions: esophagus, gastric mucosa without visible changes. Since then, the hospital database has 635 documents about this patient (studies, consultations, extracts, descriptions of radiological studies): 63 radiological studies (12 radiographs, 9 computed tomography (7 lungs and 2 abdomen)) , 6 nuclear magnetic resonance (2 head, 4 spine), 3 colonoscopy, 22 echoscopies (6 abdomen), 7 bronchoscopies, 11 pulmonary functional tests, 3017 laboratory tests and only 1 psychiatrist consultation. In 14 years patient came to the hospital for persistent non-allergic bronchial asthma, chronic bronchitis, chronic pharyngitis, gastric reflux, primary arterial hypertension, cervical cerebral palsy, chronic radiculopathy, left abdominal pain, severely corrected labile glycemia, general weakness, facial swelling, frequent urination at night, type II diabetes mellitus, autoimmune hepatitis, hepatitis C, lung sarcoidosis, nodular rash, allergy to Baralgin medicament, cough, sputum, chest discomfort, unstable febrile fever, dyspnea episodes, irreversible dermatitis of the buttocks, squeezing pain in a heart area, pain in a left hand and left side of the head, physical intolerance, heart rhythm disturbances, mouth mucosal sensitivity, ulceration, fluctuation of blood pressure, recurrent infections, melting hands, right side pain, abundant defecation with indigested food, liver cirrhosis, blood clotting disorder, cholesterol increase, "painful liver", muscle cramps, neck pain spreading to the left hand, impaired eyesight, stroke, bladder cancer. Objective studies were usually not pathological, and the diagnosis was often "stretched" to something familiar. Also, each time the patient is told that she is not ill, she becomes sad and expresses new symptoms and complaints, asks for hospitalisation, additional research and medical advice. November 06, 2013 - Psychiatrist consultation (hospitalised in Endocrinology department): patient complains about anxiety because of her somatic illness, lack of energy, falling weight, sleep disorders. She associates her illness with psychogenesis (loved one's funerals) and earlier diagnosed somatic diseases. Feeling bad for 5 years and complains that she was not consulted by a psychiatrist but episodically used neuroleptics. Not treated consistently. **Objectively:** Tense, anxious during the whole conversation. The story is lacking in fluency, consistency. Hypochondrial, accented by somatic diseases, the sensations they cause and repeats all her somatic problems during all conversation. The mood is humiliated, the emotions are labile, quick grieving. Any remedy for a medical condition is refused by a reason of poor liver condition. Patient wants to try to help herself with the help of psychologist. **Conclusion:** There is currently a lack of monitoring data to formulate a diagnosis, a psychodiagnostic test is required. The patient was advised to go to the psychiatrist's where psychologist consultation and psychodiagnostics tests would be directed. December 4, 2018 - Last Hospitalization at Pulmology Department: **Complaints and history:** The patient have recently completed treatment for hepatitis. Complaining of shortness of breath during physical examination, breathlessness - can only reach the second floor, feeling discomfort on the left side of the chest (long period), melting left hand, tiring muscular cramps. Recently, there has been a study at the Pulmonology Department, although a history of sarcoidosis, bronchial asthma and a diagnosis of bronchiectasis without significant pathology with only one single bronchiectasis. The patient has been taking prednisolone 5 mg for many years (due to autoimmune hepatitis, the gastroenterologist considers this treatment to be inappropriate for the liver, should be discontinued). The patient then returned to the gastroenterologist requesting tests for possible liver cancer. When asked to seek psychiatric consultation, the patient was angry: "how dare You suggest this?". As the doctor refused to investigate the patient because of the reason that she had no gastroenterological pathology, the patient turned to the urologist (states that she was urinating with blood, although not found in the tests) and to the neurologist (due to a pain of a back and left side of chest).

Table 6: 2nd clinical case.

Patient 48 years old, closed community leader. In childhood he was beaten by his father, has never been praised. Currently occupying the highest position in his community - he does not receive the praise, consolation and attention. Patient in 2014 applied to the family doctor for insomnia, fatigue. Complaints seemed logical especially as the patient travels to Canada for work and the differences in time zones can cause such symptoms. The family doctor recommended Circadin to follow the work and rest regime and to reduce work-related stress. After 3 months in the absence of effect, Stilnox 10 mg has been prescribed for a short period. According to the patient after 3-4 months the drug did not help him, but the patient admitted that he often took 2 tablets and asked for more sleeping pills. A doctor in the area has been advised to stop taking sleeping pills, contact a psychotherapist or a psychiatrist. Patient did not agree, demanded medicines because long trips to the United States were planned. It is recommended to take Bromazepam 1.5 mg only in case of insomnia after a trip or during high stress. Such complaints and treatment continued for 4 years. Patient also did not accept to visit a psychiatrist because he is a well-known person. He was planning a meeting with a psychotherapist, but he did not go because he spent a lot of time on business trips abroad. When he received attention from the doctor, patient began to visit him more often and continued to complain (weakness, insomnia, fatigue, "something to me", "something sick") - although there was no objective change except for overweight and dyslipidemia. Due to the worsening of dyslipidaemia the patient agreed to start training, but insomnia and persistent anxiety persisted. In 2018 after a 3-week holiday in Greenland, the patient came to the family doctor complaining that his health was getting worse after the holiday. He claimed that he had no strength at all, could not stay at work as long as usual, sometimes wanted to hide from people and even waiting for a response in order to change his work. Tests results - no pathologies were found. The patient once again demanded sleeping pills and expressed a desire to go to the hospital for an examination. Family doctor recommended Sertraline 50 mg/d, Stilnox 10mg/d and recommended psychiatrist and psychotherapist consultation. At that time, the patient's mother was under hip surgery and had to take her home and take care for her for two weeks. The patient avoided traveling, looking for health reasons to be unable to travel, perhaps because life with his mother made associations about his childhood when he suffered violence. While taking Sertraline and Stilnox without effect after 2-3 weeks the family doctor once again offered a psychotherapist consultation and the patient agreed because the family doctor was his great authority. After a psychotherapist, the patient agreed to contact a psychiatrist privately. Following private psychiatric consultation, Sertraline and Quetiapine were prescribed. After a little improvement in symptoms, the patient noticed that anxiety was improving and at that time he had to take his mother to her native city, and he went to the private clinic there where he was treated for 10 days. According to the patient, Quetiapine was given at 100 mg, but the duration of sleep was 1-2 hours. After switching to 200 mg of Chlorprotixen, sleep improved but there were clinically significant physical side effects (urinary retention). The patient continued to take Sertraline, improved mood, calmness but still had insomnia (0.25-0.5 tablets given Clonazepam but he because of that he complained about morning headache and dizziness). After the hospitalisation in a private Clinic in other city, patient did not complain about the insomnia anymore, so family doctor suggested to return to his work and to take care for his mother. The patient said his condition was not good and he would not be able to live with his mother in this condition. By the way, in the event of side effects, he no longer wants to be treated privately with a psychiatrist but agrees to be treated with a psychiatrist in a public institution. August 20, 2018 consultation by psychiatrist of hospital: Adaptation disorders (acute and first identified in life chronic diseases) were found. Status rating information: Mental state: Communicates willingly. Thinking at a moderate pace, consistent. The questions are answered meaningfully. The mood fluctuates in the background of stress. Do not say suicidal thoughts. There is a pathological anxiety associated with difficulty sleeping. Complaining insomnia. Recommendations for treatment, nursing, work, outpatient care: due to inadequate outpatient treatment effect (clinically significant symptoms did not disappear using tranquillizers) patient is directed to treatment at Vilnius Psychiatry Day Hospital. September 20, 2018 contacted the family doctor after Vilnius Psychiatry Day Hospital. No longer taking sleeping pills, Sertraline also discontinued, prescribed Tisercin 25 mg per night. The patient wished to have Stilnox and Bromazepam in reserve if there was a worsening, but the family doctor refused and only Tisercin 25mg was prescribed and recommended to consult a psychiatrist for further treatment tactics and dose reduction. The patient refused to take care of his mother and hired a man for that. Currently, the patient can do his own business, does not complain of insomnia, fatigue or lack of strength. Because he felt anxiety about his dyslipidemia - he was examined by a cardiologist for heart prevention program. After cardiologist consultation family doctor prescribes statins to treat dyslipidaemia. Patient continues to visit a psychotherapist and planned a psychiatric consultation for further treatment tactics.

Table 7: Clinical warning signs presented in a table contribute to the diagnosis of MS by proxy [14].

The caregiver is not satisfied with the treatment
Symptoms do not correlate with medical findings
Treatment for the victim is ineffective
Inconsistent, misleading patient history
Symptoms appear when the caregiver is nearby
The victim's brothers / sisters also have unusual symptoms
The caregiver asks for public compassion and gifts / donations
The caregiver does not feel relief when the victim's symptoms are relieved
Atypical symptomatology

Table 8: 3rd clinical case.

November 18, 2012

Girl 3 years and 9 months

Complaints: The patient is afflicted by 3 white ulcers on the inner corner of the lower lips with a red mucosa around the ulcer.

The history also includes other complaints: relapsing ulcers in the mucous membrane of the mouth, genitalia, changes in the lining of the lips, skin rashes, stools in faeces, fast fatigue, especially in the background of physical exertion, morning sluggishness, irritability, subfebrilitet, day and night enuresis, increased diuresis.

Life history:

Oral mucosa appeared at the age of 14 months. In the first year, the ulcers were repeated 2-8 times a month. In the second year, the ulcer became visible every day. They caused pain, influenced the diet. The ulcers are also localised in the cheek area, at the end of the tongue, the last time also appeared at the lip mucosa. Ulcers in a genitalia area appeared 3 times during the time of a disease.

Repetitive lip lesions (cheilitis) have occurred after eruptions of perchediasis. Ezogastroduodenoscopy was performed. In the first case, chronic esophagitis, reactive gastropathy was diagnosed but no alterations were found when tests were made for one more time. In both cases, the biopsies of the duodenum were free of pathological changes.

Skin rashes have been observed from 2.5 months age. In infancy there was a hairy head rash (seborrheic dermatitis), sweating behind the ear. The wrinkle rash in the wrist area occurred within 1 year and 5 months ago, after 3-month rashes in the lower leg appeared; later at age 1year 9months rashes appeared at the buttocks and left arm with the glossy surface; at the same time a different kind of rash appeared - a small hemorrhagic rash on the limbs.

Histological diagnosis: possibly Pityriasis licheinoides et varioliformis acuta (acute lichen and leprosy).

Notices the green solid faeces every 3 days and only after the microlax enema or by using glycerin suppositories or vice versa - liquid feaces for about 2 weeks 7-8 times a week every 1.5 months. A colonoscopy was performed on 28.03.2012, the thick intestine to the ileocecal angle was examined, the histological changes of the mucosal macroscopic and in biopsies were not found, dolichosigma was found.

Subfebrilitette has been noticed since 04.2010 (13 months old) so far.

Irreversible diarrhea (day and night) occurred between at the age of 1 year and 9 months after the rotavirus infection. Its frequency is from 20 times / month up to 3 days / month. Exacerbations often coincide with the onset of infections.

In the electroencephalograms of 04.04.2012 and 10.2012, epilepsy-like activity has been shown to increase during photostimulation.

From 09.09.2009 to 11.11.2012, patient visited the Children's Hospital Children's Consultation Clinic for 95 times.

The patient was advised by a wide range of specialists on various complaints and symptoms told by parents:

Pediatric gastroenterologists diagnosed functional digestive disorders, tendency to constipation, stagnant blood impurities, recurrent stomatitis.

Various studies were conducted to exclude rare and severe diseases.

Geneticist counseling and additional research were performed. The organic acid test was performed for 3 times. All urine specimens tested were free of compounds of type I tyrosineemia.

Children's hematologists diagnosed symptomatic lymphocytosis, anemia of iron deficiency and studied changes in the coagulogram. Conclusion: "There is no data on haemostasis pathology and blood disease".

Children's nephrologists have diagnosed microhematuria several times, tests have been carried out (urinary sonoscopy, urine tests, biochemical blood tests). No treatment has been prescribed for a found microhematury.

Child neurologists have been watching the girl's development since childhood. In childhood muscle tone disorder syndrome, neuroreflex irritability was diagnosed. Later when parents noticed unusual changes in the girl's condition, paroxysms were investigated.

A child endocrinologist advised a girl about suspected paroxysms caused by a carbohydrate metabolism disorder. Conclusion: "The evaluation of the available data currently excludes endocrine pathology".

Children's allergologists examined the patient for skin lesions and digestive disorders, a food allergy was suspected. Allergy samples were taken.

In suspected systemic connective tissue disease, the patient was consulted by a rheumatologist in children. Final diagnosis of pathology: Licheinoid dermatitis, potentially acute lichen and leprosy (Pityriasis licheinoides et varioliformis acuta).

Currently, objectively: a girl is in a satisfactory condition, without any life-threatening pathological syndromes. No fever. Weight 15.3kg, height 105 cm. A darker area of the eye. Tonnes are small. The lower lip mucosa has 3 ulcers. The small back lymph nodes can be tactile. Skin dryness, papules rash in the armpit area (keratosis pillaris type). Heart tones are clear, rhythmic, and 1st grade systolic murmur is heard. Belly soft, liver, spleen not increased. BCS Scar (+). No lumps are heard in the lungs.

Diagnosis: Unspecified immunodeficiency (D84.9). Relapsing oral mucosa and genital ulcers. Licheinoid dermatitis. Fructosemia?

The doctors' consortium decided to continue the examination of the patient for congenital metabolic diseases. Patient DNA testing for fructose is recommended. There are no possibilities to investigate a child for fructosemia in health care facilities in the Republic of Lithuania. The study was made by a Mannheim Human Genetics Center (Germany). The patient has not been diagnosed with any congenital disease. Mother began to threaten the court and demand a full genome investigation.

It turned out that her mother was suspected of having a malignant tumor before she was giving a birth to her daughter. At that time, she received a lot of atten-

tion and compassion from the relatives. The diagnosis of malignant tumor was denied, attention and compassion disappeared, and a healthy daughter was born. Because of the strange behavior of the mother and the suspicion that the girl had ulcers in the mucous membrane of the mouth and genitalia could have been made specifically by her mother, as well as staining the stool with green color and other symptoms - suspecting MSBP, the 20 doctors that treated a girl at the doctors' consulate decided to sue mother for damage to the girl. The mother was deprived of her maternity rights and her father was given custody.

Letters from patient's mother's and doctor's communication:

Doctor:

Dear X,

XX has no suspicion of lupus, it is a very serious disease, and if your daughter would have at least the slightest suspicion, she would have been treated for a long time with maximum doses of prednisolone and other immunosuppressants. Because without them, children die. I'm sorry for the rudeness but I'm tired of your suggested diagnoses. I will give you an answer to ANA's investigation. Even with 1 mg / kg, there is no high dose of prednisolone, and we always round off the weight, so I did not understand this argument. On the other side, Fabry's disease is treated by neurologists. I'm afraid to go wrong but when you were in a department, neurologists probably sent out tests for Fabry's disease. I can't answer you about this properly. If you do not trust me, you can try other doctors.

Mother:

Good day,

I was wrong about ANA's investigation. It was done 04-2011, 11-2012 doctor Y prepared a response VASPVT planned to perform ANA ANCA HLA B51 but her good wishes was possibly limited "from above", so ANA test was performed 3.5 years ago. After fever: about 5 hours of stagnation, my daughter was unable to sleep, showing pain in the ankle, she was showing the same ankle at the end of the fever in the hospital during the last treatment. It is reported in the literature that 1 mg prednisolone / 1 kg body weight is a high dose. My daughter was given 15 mg / 16kg. I have read a summary of Fabry's disease history, as well as we had allergy, immunodeficiency diagnoses, were treated with prednisolone, 1 x false negative response of Fabry's disease from an Italian laboratory, the disease was diagnosed after complications, although expensive drugs were used. 10-2011 and then several times after that I wrote a request to send a girl to a foreign medical institution for diagnosis, but the requests were justified. It is incomprehensible to me how my daughter did not get any studies on lupus until today while the allergen palette has been done 3 times, skin prick, patch samples for 2 times, IgE repeated for 5 times until finally got a result of 0.38. Not sparing our hospital finance or child's health because the diagnosis of food allergy was more important than logic and child's health.

syndrome (based of medical literature review) so that doctors could better realised criterias of MS and the data would be of the highest quality. If the message was not read a short description of the disorder by Kaplan and Sadock's [5] was also included in the questionnaires. Electronic survey was consciously refused because Munchausen syndrome is not well known, and it is very important to be sure that doctors have correctly understood and filled the questionnaires. The survey was conducted from the beginning of October 2018 until 26 January 2019. Data processed using Microsoft Excel 2016 and RStudio.

Results

A total of 367 doctors from 17 treatment facilities were interviewed. 9 questionnaires were filled in incorrectly and data from 358 surveys were used. Also, some doctors did not answer part of the questionnaire. The majority of respondents were family doctors 166 (46%) and pediatricians 82 (23%). The specialization of the doctors interviewed is presented in Table 9.

MS and MS by proxy prevalence

According to the data of the Department of Statistics of Lithuania in 2019 [17], 547 484 citizens lived in Vilnius and 3291 doctors worked. 358 (10.9%) of the capital's doctors who reported 669 patients with MS and MS by proxy participated in our survey. We hypothetically calculated that in Vilnius there are around 6150 such patients (1.12%).

The remaining part of the results are discussed separately with the results of a physicians survey on MS and pediatricians survey results on MS by proxy.

Results of doctors' survey on MS

A total of 276 doctors were interviewed, most of whom were family doctors 166 (46%). Most doctors 222 (80.43%) knew about MS before the survey. 152 (55.07%) of respondents say that they have not detected MS in their clinical practice. A total of 501 patients were identified as having MS by doctors answers. 108 (90%) doctors recommended psychiatric consultation. The majority of patients were women 273 (89.42%). Average age of patients 42.64 (± 12.17) years, median 45. There was no significant age difference between the sexes (Table 10). The majority of women 69 (36.51%) and men 18 (60%) are single, although a significant proportion of women are married - 55 (29.10%). The most common complaint of patients is pain 163 (38.90%). Other patient complaints are presented in Table 11.

Results of Physician Survey on MSBP

A total of 82 pediatricians were interviewed. Most of them - 77 (93.90%) knew about MS by proxy before survey and 46 (56.10%) doctors said they had patients with MS by proxy in their clinical practice. A total of 168 clinical cases were identified. 50 (60.98%) doctors did not recommend psychiatric consultation. Almost all MS by proxy holders are women 105 (96.33%) and the male population (4 (3.67%)) is statically insignificant and is not included in further calculations. The average age of women is 36 (± 5.6) years old while the median is 35 (Table 12). The majority of women are single 20 (41.67%) or divorced 15 (31.25%). The majority of MS by proxy victims complained of pain 47 (23.20%) and fever 46 (22.70%). Other patients' complaints are presented in Table 13. For the end of the results Table 14 provides additional doctors comments describing the MS and MSBP patients complaints.

Discussion

We will discuss the prevalence of MS and MSBP in the capital, doctors knowledge of these disorders and other

Table 9: Specialization of the interviewed doctors.

Doctors' specialization	Amount of doctors	Amount of doctors (%)
Family doctor	166	46%
Pediatrics doctor	82	23%
Dentist	19	5%
Inner medicine doctor	17	5%
Surgeon	16	4%
Neurologist	9	3%
Cardiologist	8	2%
Ophtalmologist	8	2%
Allergologist	6	2%
Pulmonologist	4	1%
Gastroenterologist	3	1%
Endocrinologist	3	1%
Medical doctor	3	1%
Obstetrician-gynecologist	2	1%
Otorhinolaryngologist	2	1%
Dermatologist	2	1%
Geriatrist	2	1%
Intensive care doctor	2	1%
Nephrologist	1	0%
Urologist	1	0%
Radiologist	1	0%
Infectologist	1	0%
Total:	358	100%

Table 10: Age of MS patients.

Average			Median			Standard deviation		
All	Women	Men	All	Women	Men	All	Women	Men
42.64	43.26	39.62	45	45	4000%	12.17	11.83	13.54

Table 11: Complaints from MS patients.

	Complaints	Total	Percent (%)	Description
1	Pain	163	38.90%	Pain (doctors did not name localisation specifically) N = 81; abdomen N = 23; heart N = 21; back N = 10; chest N = 9; head N = 9; tooth N = 3; tongue N = 2; knee N = 1; face N = 1; liver N = 1; vaginal N = 1; mouth N = 1.
2	General	66	15.75%	Many general complaints that are every time different during each visit and not specific.
3	Fatigue	37	8.83%	
4	Abdominal	22	5.25%	Doctors have named general gastrointestinal disorders N=10 ; nausea N = 6; Lack of appetite N = 2; diarrhea N = 2; eating more than "going out" N = 1; abdominal abscess N=1.
5	Chest	20	4.77%	Shortness of breath N = 15; cough N = 4; respiratory tract infections N = 1.
6	Head	20	4.77%	Dizziness N = 20.
7	Heart	20	4.77%	Increased blood pressure (at home only) N = 11; tachycardia N = 8; decreased blood pressure N = 1.
8	Skin	12	2.86%	Itching N = 7; rashes N = 4; skin blister N = 1.
9	Wounds	12	2.86%	Quite cleverly makes self-cut wounds or knit with needles, scratches to wounds, high desire for surgery N = 11 *; feeling sure that facial acne is worms that scratch skin up to wounds N = 1.
10	Fever	9	2.15%	
11	Insomnia	8	1.91%	
12	Anxiety	7	1.67%	
13	Sweating	6	1.13%	
14	Tongue	2	0.48%	White tongue N = 1; tongue swelling N = 1.
15	Throat	2	0.48%	Throat dryness N = 1; foreign body in a throat N = 1.
16	The abscesses	1	0.24%	Causes self-made abscesses
17	Adrenal glands	1	0.24%	Complains of a bad adrenal activity
18	Syncope	1	0.24%	
19	Weakness	1	0.24%	
20	Endocrine	1	0.24%	Thirst, high glucose (at home only), objectively within the normal range
21	Ocular	1	0.24%	Says that doesn't see anything

22	Gynecological	1	0.24%	Discomfort in the vagina
23	Motional	1	0.24%	Complaining about immobility
24	Paranoia	1	0.24%	The patient says: "Everybody hides a diagnosis from me, everybody is lying to me, I know I'm sick"
25	Parasites	1	0.24%	Says that he/she has parasites
26	Psychological	1	0.24%	Has a lot of phobias, apathy
27	Seizures	1	0.24%	
28	Urinary	1	0.24%	Erythrocytes in urine
	Total:	419	100.00%	

*there are made 14 surgeries for 1 patient during 40 years.

Table 12: Age of MSBP patients.

Average			Median			Standard deviation		
All	Women	Men	All	Women	Men	All	Women	Men
36	36	-	3500.00%	35	-	5.6	5.6	-

Table 13: Complaints from MSBP victims.

	Complaints	Total	Percent (%)	Description
1	Pain	47	23.20%	Abdominal N = 18; Pain (doctors did not name localisation specifically) N = 16; Head N = 12; Heart N = 1
2	Fever	46	22.70%	
3	Fatigue	32	15.80%	
4	Abdominal	31	15.30%	Nausea N = 20; diarrhea N = 4; vomiting N = 3; eating disorders N = 3; lack of appetite N = 1
5	Chest	9	4.43%	Cough N = 5; shortness of breath N = 2; asthma attacks N = 2
6	Skin	7	3.45%	Rashes N = 3; skin damage N = 3; itching N = 1
7	General	5	2.46%	Many common complaints, each time they are different and not specific
8	Joint	5	2.46%	Joint redness N = 4; arthritis N = 1
9	Seizures	4	1.97%	Epilepsy attacks N = 2; seizures N = 2
10	Behavior	3	1.48%	Activity and attention disorder N = 2; autism N = 1
11	Motional	3	1.48%	
12	Heart	2	0.99%	Heart failure N = 1; myocarditis N = 1
13	Infections	2	0.99%	
14	Weakness	1	0.49%	
15	Insomnia	1	0.49%	
16	Nasal	1	0.49%	Nose "block" because clogged blood "clogs"
17	Feces	1	0.49%	Worms in feces
18	Thyroid	1	0.49%	Changes in thyroid
19	Seizures of unclear origin	1	0.49%	
20	Urinary	1	0.49%	Changes in urine
	Total:	203	100%	

Table 14: Doctors' additional comments on MS and MS by proxy patients' complaints.

1. "Every time it hurts another place, patient's lack of attention is felt while communicating"
2. "Local 2 cm pain in liver projection, desire for interventions, great history of the disease."
3. "Vomiting without reason, eating more than 'going out'".
4. "Everything hurts, explains everything in a very picturesque way. Describes that there was a "trapped" foreign body in the esophagus haven't been found after the fibrogastroduodenoscopy. After meeting family doctor, "myocardial infarction" began at the reception. "
5. "The doctor did not personally encounter but had a colleague that had a patient whose husband used to inject mercury into the buttocks for no reason. The patient is being treated."
6. "Abdominal abscesses that during surgery were not found".
7. "Many complaints"
8. "There is no justification for various complaints."
9. "Diarrhea starts in 10 minutes when in a hospital."
10. "Weakness, complaining about the neighbour who hit although, there are no signs of violence, many complains, requires treatment."
11. "The child's" condition doesn't change besides any treatment".
12. "Nose" block "because of blood clotting"
13. "Desire for Research and Doctor Consultation."
14. "Self-mutilation (scarring), desire to have more operations (14 operations over 40 years of life."
15. "Melting, hurting, fainting, self-induced abscesses, diarrhea, loss of vision, falling blood pressure."

16. "Damages her/his face because it feels that acne is caused by “worms " - white animals; feels sure that all the body is covered with fungus, pain in joints, itchy skin, asks for medicines.”
17. "Everything hurt in the oral cavity, thinks all teeth wobbled."
18. "Complaints are all that can be imagined.”
19. “Patient wants to be sick, behaves offensive if you don't find anything wrong and ask for the advice of another doctor.
20. “They are medical tourists. I do not offer a psychiatrist consultation because I am afraid to offence the patient”

demographic (patient gender, age, social status) results as well as patients complaints and also cooperation between doctors and psychiatrists while treating somatic diseases.

We interviewed 358 (10.9%) capital’s doctors who reported 669 patients with MS and MSBP. We hypothetically calculated that in Vilnius there is about 6150 (1.12%) such patients. Our results match the literature data. Weber and Doyle argue that MS has only 1% of hospital patients [2], Kaplan and Sadocks said it is up to 1.3% [5]. Abeln and Love found that MSBP contains 0.04% of all patients [6] and according to a Caselli et al., MS should be between 0.6% and 3% of general practitioners patients and 0.02% to 0.9% of medical practitioners patients [18]. Italian doctors investigated 751 cases in one of childs hospitals suspected of having MSBP and even 21.4% of cases matched the diagnostic criteria. This high prevalence (much higher than in other literature) they explain that a prospective study was conducted with a specially trained multidisciplinary team [11].

Our study showed that out of 358 respondents, even 124 (44.93%) doctors and 46 (56.10%) paediatricians thought they had MS and MSBP in their clinical practice. Our results show that this topic is important because almost every second doctor in Vilnius thinks he or she is facing MS. This means that capitals doctors working in health care institutions must not only treat patients with somatic illnesses but also be able to recognize and know how to deal with patients with artificial disorders because ignoring these “hospital tourists” (as one doctor says) does not solve the problem but on the contrary - it creates a vicious circle just increasing the workload of doctors and making them psychologically tired. Therefore, it is important to continue to treat somatic diseases when MS is suspected, and as a result to have a motivating interview with the patient in an effort to motivate him or her to turn to professionals who are experienced / skilled in working with MS. It is also important to emphasize that the MSBP is violence against children. Therefore, an appropriate response should be provided by informing children’s rights and providing long-term psychological support to the family in cooperation with psychologists.

The challenges posed by patients with MS are relevant worldwide and are addressed differently by different countries. Canadian scientists believe that general practitioners are most likely to meet patients with mental disorders. Since 2005, the primary health sector has been restructured in the Canadian Quebec region to improve cooperation between general practitioners and psychiatrists in the treatment of psychiatric patients. Patients and staff members at 95 local hospitals were transferred from hospitals to primary health care centers called health and social service centers where mental health care teams were formed, and some large hospitals developed assessment communication modules to provide rapid psychiatric assessment and treatment recommendations [19]. Interesting MS and MSBP patients are being monitored by Norwegian doctors. In this country all residents have a personal code that is sent to all patient-related health institutions, accompanied by a full patient history with diagnosis F68.1. The Norwegians followed the MS for several years (15 years in one case), and the results showed that MS patients stopped their behavior or at least severely reduced it due to their rapid identification in medical institutions. Some doctors do not like this policy because they believe that the patient is being stigmatised. However, in the Norwegian view, attempting to protect a patient from serious self-harm, which sometimes threatens life, is an ethically superior goal than passively allowing the patient to continue his behavior [14].

Our study showed that 297 (82.96 %%) of physicians in Vilnius know MS. 61 (17.04%) doctors did not know about MS before the survey. 54 (19.57%) physicians were not aware of MS while only 5 (6.10%) pediatricians had not heard of MSBP. We have not been able to find foreign or Lithuanian research that will examine doctors knowledge of artificial disorders. However, scientists say that although MSBP is rarer than MS [6,11] but it is very important for pediatricians because it is associated with high children mortality (from 6% to 33%), violence against them, victim’s brothers / sisters damage [5]. Also, many pediatricians mentioned that they learned about this syndrome at a conference a couple of years ago during which lithuanian doc. Alvydas Navickas read the report on this syndrome. In addition, documentary films (“Mommy Dead and Dearest”), series (“The Act”) are created about MSBP.

Our study has shown that women 273 (89.42%) are more often affected by MS and MSBP have only women (105 (96.33%)). The results are consistent with the scientific literature. Tatu and co- authors say that in more than 60% of cases, patients are young women [3], and other researchers also consider that women are mostly young [2,5,6,12]. However, Boston scientists have a slightly different opinion. They say MS is more common in men, and women are more likely to experience other, lighter forms of artificial disorders [15].

The study showed that most people with an artificial disorder are middle-aged: MS 42.64 (± 12.17) years, MSBP 36 (± 5.6) years old. Similarly, after examining the MS age chart (annex 3) in MS, two ages peaks are emerging with the highest number of patients: the period when a person becomes a young adult (25-30 years) and when the middle age crisis begins (45-50 years).

In the case of MSBP, the majority of patients are between 30 and 35 years old. Our results match the literature. Kaplan and Sadock argue that MS have mostly middle-aged people (35-50) [5] while Tatu writes with other authors that more than 60% of people with artificial disorders are young women [3]. Thus, MS occurs at a young age, so it is important to respond to suspected disorder in a timely manner and to provide appropriate care to the patient in order to improve the quality of life in the long run.

In our study, many doctors did not fill in the section on social factors so to interprete it in most aspects is inappropriate. However, one of the most notable trends is that both MS and MSBP patients were mostly single. Most scientists have the same opinion [2,3,5,6,11,14] and Boston scientists believe that men with MS are more socially isolated (for example, have no visitors during hospitalization) [15].

Our study showed that MS patients most often complain of a pain while MSBP of pain and fever. Our data coincides with literature. According to Kaplan and Sadock, the most common complaint is fever as it is the easiest to cause [5]. According to Italian researchers, fever and abdominal pain are also commonly reported in patients with MSBP [11] and Weber and Doyle consider the most frequent complaints of the abdomen and chest: pain, vomiting and / or diarrhea, anemia, hypoglycaemia, infections, seizures, skin lesions and atrophy [2]. Most scientists believe that the spectrum of MS complaints is very wide, and it is difficult to choose the most common ones so often only the complaints of specific clinical cases are distinguished in the articles [3,6,12,15].

Our study also revealed that 108 (90%) physicians and only 32 (39.02%) pediatricians have recommended psychiatric consultation for those who have MS. During the survey, one doctor wrote a comment about offering the psychiatrist's consultation: "[...] The doctor does not offer a psychiatrist consultation because he is afraid to offend the patient. Thus, the passivity of some doctors about psychiatric consultation can be linked to the defensive medicine. In 2011-2013 a research conducted by Professor Liutauras Labanauskas on the prevalence of defensive medical phenomena in Lithuania revealed its high level in our country and the main source of this problem is a defective system that defends doctor's rights. This means that thousands of extra patients in queues are just waiting for the doctors who directed them to formally defend

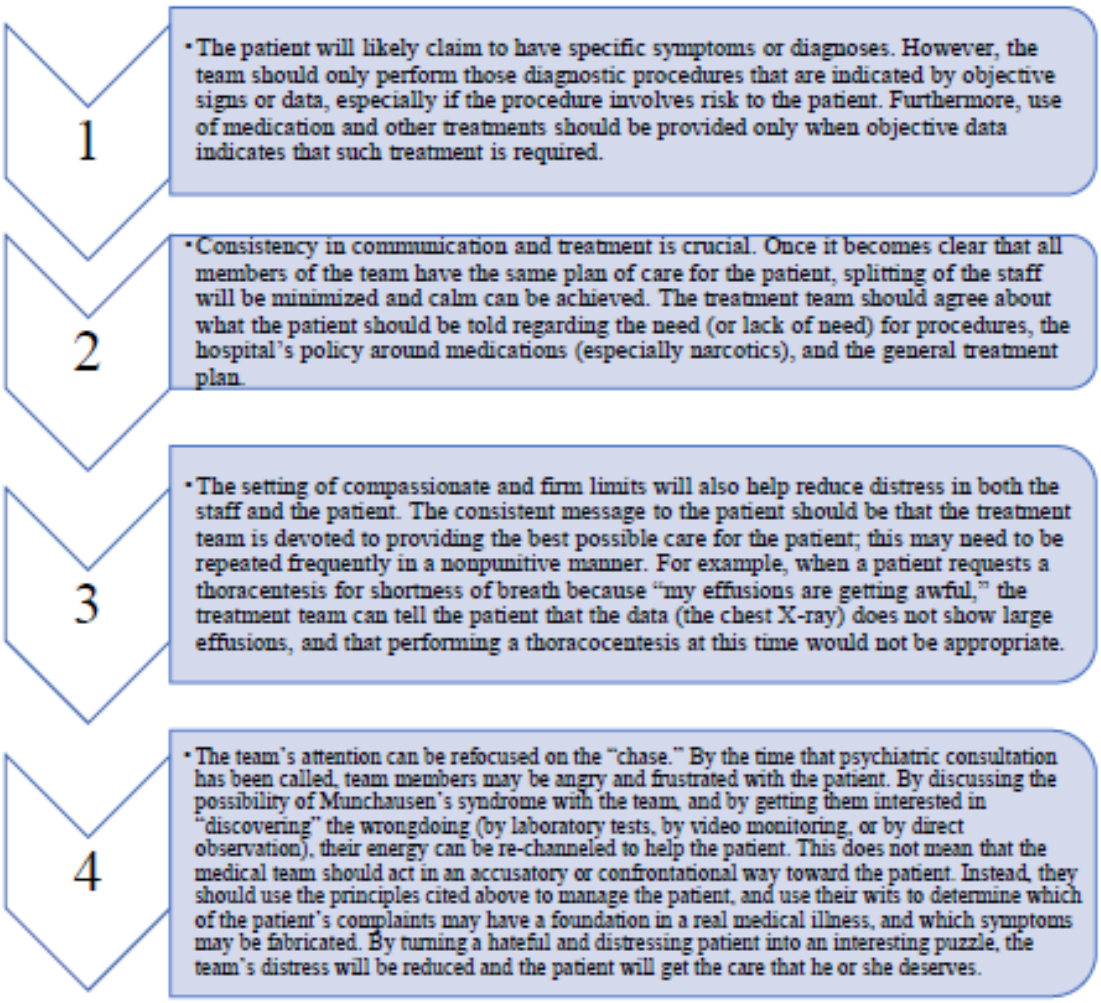

Figure 1: Four principles of management can be communicated to the medical team [15].

themselves against possible legal liability and other reproaches which is the worst for those patients who are really in need of consultation or research. In addition, a particularly high prevalence of defensive reactions has been identified among the professions that require the versatility of doctors (general, internal, pediatrics). The study also highlighted the importance of the clinical situation and the reactions of doctors. In order to reduce the manifestations of defensive medicine in the health care system, the need to improve the professional training of doctors has been revealed. In the professor's opinion, the possibilities of psychological help, education, development of new competences, meditation methods in the professional activities of doctors are unused [20,21].

Conclusions

1. The prevalence of Munchausen syndrome in Vilnius is 1.12%. These data are consistent with world medical literature data.
2. Most doctors in the city of Vilnius know Munchausen's syndrome.
3. Most doctors do not offer psychiatric counseling to suspected MS patients due to defensive medicine.

Practical offers

Train primary care professionals on how to communicate with patients with MS. An effective tool would be to develop recommendations for fast MS and MSBP assessment and management. For example, Huffman and Stern 4 principles of management in Figure 1 [15]. It is also important to improve the integration of the psychiatric team into the primary health care sector with the aim of improving cooperation between doctors and psychiatrists in the treatment of patients with artificial disorders.

Declaration

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