



Fever in Munchausen syndrome

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Abstract. Munchausen syndrome is a clear indication and production of special pathological symptoms (artificial disease), which is considered a mental disorder, which is also associated with serious emotional stress. Such individuals inevitably or gradually suffer from severe illnesses, suffer from medicinal drugs and repeatedly succumb to various painful methods of treatment and surgical procedures, which ultimately lead to significant loss of health. Nowadays two version of disease are defined: the classical version and the Munchausen syndrome due to trust (delegation), which involves the influence of abusers on their own children or on dependent persons. The possibilities of diagnosing such a condition are significantly limited by the characteristics of the patients' behavior and the impossibility of forced psychiatric intervention. Such persons create precedents for medical errors, complaints and lawsuits. Patients with Munchausen syndrome represent a hidden group at risk of serious anesthetic complications.

Key words: fever, Munchausen syndrome, medication error, complications of anesthesia.

— *Baron, all these are fictions!...*

— *... they always said that I am the most truthful person on Earth.*

Raspe R.E., 1785

Introduction

Munchausen syndrome is a deliberate invention and production by a person of pathological symptoms (artificial illness), which is considered a mental disorder because it is associated with serious emotional difficulties. Currently, such a condition in certain cases is understood as a simulated disorder in relation to one's own person, which is characterized by pretending, falsifying or provoking in oneself somatic, psychological, behavioral manifestations and symptoms. These patients do not seek secondary gain and cause symptoms independently and unconsciously without any specific motive and goal of material gain or evasion of any social demands. This is the difference with simulation, when such behavior is motivated solely by obvious external rewards or incentives.

Goal: based on the available literature data, determine the influence of Munchausen syndrome on the development of fever of unknown origin and the risk of anesthesia complications.

Materials and methods

Selection articles were included for the study if they (1) were published in English, Ukrainian, and Spanish, (2) reported on health disorders associated with Munchausen syndrome, (3) reported on the development of fever of unknown origin and complications of such conditions, (4) used a cohort or cross-sectional design of an observational study. A retrospective information search of information sources was carried out according to the spatial-vector model of the descriptor system based on classifiers, supplemented by a manual search of the lists of included sources. 70.8% of the used literary sources are from the last 10 years of publication, 29.2% — from earlier years of publication.

Results and discussion

Munchausen syndrome (MS) was first described by R. Asher in 1951 in the medical journal «Lancet» [1]. In Australia and New Zealand, the term «fabricated or induced illness» is now used [2]. In the case of this disease, patients deliberately create symptoms

of a physical or mental illness in order to assume the role of the patient and receive medical care. Munchausen syndrome is a factitious disorder that includes a group of conditions in which the patient misinterprets, repeats, or induces symptoms of injury or illness without any apparent external benefit. This leads to unnecessary use of medical resources, i.e. unwarranted medical tests and evaluations, and this makes it one of the most difficult diagnoses in the medical field. In its essence, Munchausen syndrome is the opposite of hypochondria. In the latter case, a person is panicked about getting sick and attaches great importance to trivial signs, while a person with Munchausen syndrome, on the contrary, seeks to get sick in any way. Falsification of personal data makes it much more difficult to determine the true prevalence of the syndrome. Therefore, there are no reliable statistical data on how many people suffer from Munchausen syndrome in Ukraine. In the United States and Europe, Munchausen syndrome is considered an isolated disorder. It is estimated that less than 1% of patients in clinical settings have Munchausen's disorder [3]. According to the National Hospital Discharge Survey, the incidence of factitious disorder is 6.8 per 100,000 patients [4]. A recent study in Pakistan suggested that the prevalence of faking disorders is approximately 0.0001–15%, although the exact prevalence of this disorder is unknown [5].

A person decides to imitate various pathological conditions on his own. But not everyone has such a tendency, that is, the syndrome probably has a reason. This process and the factors of its development are now being seriously studied, but the only thing that has been definitively determined is that the disorder is not genetically transmitted. However, some authors suggest that mental trauma or attention deficit in childhood may be the cause of the syndrome. A possible connection with personality disorders, which are common in people with Munchausen syndrome, is also being studied. Personality disorders are when a patient behaves, thinks, feels and communicates differently than a normal person. Borderline, antisocial and schizotypal disorders are most common. Unmarried white men aged 30 to 50 years (37%) and women aged 20 to 40 years (63%) suffer from MS, often with healthcare work experience [6].

As for the medical specialties to which the falsified patients belong, the differences between the sexes of the sample are minimal: among men, the most represented specialty is psychiatry (31.5%), followed by emergency departments (16.7%) and internal medicine (8%); and for women, the psychiatric department appears in 22.1% of cases, followed by internal medicine (7.5%) and gynecology (6.5%) [6–8]. The specialties of dermatology and neurology (24.5%) were most often involved [9].

In 1977, Professor Sir Meadow R. introduced the term Munchausen Syndrome by Proxy (MSBP) in Great Britain [10], which refers to a fabricated or induced illness [11] when parents or guardians deliberately provoke painful conditions in a child or a vulnerable adult (disabled or elderly person) or invent them in order to seek medical help. Abusers are mainly women (75%) [8], mostly their own mothers or spouses (the subject is more often girls). For men (31%), it is mostly boys who are subjected to imitation pressure. At the same time, persons simulating a child's illness may themselves exhibit behavior typical of Munchausen syndrome. If the other person has a pre-existing disorder or disease, his or her symptoms are intentionally aggravated or further supported or provoked. A person seeks medical care for another person or otherwise claims that the subject has a disease, injury, or disorder based on simulated, falsified, or induced symptoms. Deceptive behavior is motivated by a variety of goals, not just purely obvious extrinsic rewards (receiving disability benefits or avoiding criminal prosecution, military service, etc.).

Currently, two variants of MSBP are defined:

- with the presence of a specific disorder in the abuser's vision of the child's state of health (usually these are women who themselves received psychotrauma in childhood);
- with parents receiving social benefits from the child's stay in treatment.

In any case, subjects of such influence are exposed to a high risk of mental and physical trauma. Affected children are often hospitalized for long periods of time and suffer from repeated, painful and expensive diagnostic procedures [12], so MSBP is a recently recognized but rare form of child abuse. This is an active, albeit unintentional, contribution of doctors to the harming of the child in response to the representation of the parents (guardians). Essentially, a caregiver provides medical (physical or mental) care to their child based on their need for the child to be recognized as sick, not on their actual health status. In this way, a triangle is formed, which includes the guardian, the child and the doctor. Although still considered rare by some specialists, its true prevalence with a broader definition awaits investigation. However, there are reports of this form of abuse from different countries [2, 13]. In a fabricated or induced illness, the child is harmed through the behavior and actions of caregivers, which are carried out primarily to convince doctors that the child's physical and/or psychological health is more impaired than it actually is. Harm to the child is caused directly by the guardians, as well as often unintentionally by the answers of doctors [2, 13].

Regarding the prevalence of all stressful events in connection with Munchausen syndrome, the following results were found: 20.2% of patients show stressful or traumatic events, 14.6% had physical or sexual abuse or neglect in childhood, 16.9% show abuse of psychoactive substances, 10.7% have conflictual and/or unstable interpersonal relationships, and 7.2% show premature close loss. Also, 13.4% of patients have suicidal behavior [6]. In 28% of cases, the abuser/perpetrator had a psychiatric diagnosis, i.e., depression in 14%, isolated sham in 10%, and personality disorder in 7%, approximately 75% had a history of self-induced somatoform or artificial disorder, and about 20% had a history of substance abuse [14].

Psychiatric Examination and Prosecution «MSBP by proxy» refers to an offender who is usually the guardian of a minor or a subject with a disability, i.e. is responsible for fabricating and falsifying such symptoms [14].

Most of the simulated signs in persons with Munchausen syndrome are associated with physical diseases (chest pain, stomach problems, fever, etc.), mental disorders are much less often fabricated. Individuals with MS have brief bouts of symptoms (fake the disease only a few times). However, in most cases, a person pretends to be sick for a long time.

As a diagnosis of exclusion, we should consider febrile fever. It is a febrile condition that is simulated by the patient (Munchausen syndrome) or parents/carers (Munchausen syndrome by trust). Such a condition should be suspected in cases of hyperthermia with an atypical clinical picture (too short spikes or no evening temperature rise). A normal level of reagents of the acute phase or hyperthermia is determined by clinical signs, that is, discrepancies between the temperature and its effect on vital indicators (absence of tachycardia and tachypnea during hyperthermia), as well as non-detection of fever by another observer [15].

Fever was registered as early as 1987 as one of the most frequent symptoms of MBPS (>44%), found in 10% of cases together with bleeding (44%), seizures (42%), CNS depression (19%), apnea (15%), diarrhea (11%) and vomiting (10%). Fever in MBPS can result from induced infections, but also when information is misreported or falsified through manipulation of thermometers, physically induced hyperthermia or falsification of records. Fever in MBPS has also been chemically induced by the intentional administration of diazoxide, alimemazine, ipecacuanha, or mercury poisoning [6, 11, 12].

- An important parameter is the patient's unusual behavior (86.2%), followed by treatment failure and/or a high rate of disease recurrence (83.7%) [6].
- Possible warning signs of Munchausen syndrome:
- Very good knowledge of medical terminology and signs of diseases.
- Remarkable artistic abilities.
- Symptoms appear only when the patient is not alone.
- Identity and self-esteem issues.
- Singleness.
- Abuse of medical services.
- Registration in chat rooms according to a certain nosological form.
- Hiding information about previous hospitalizations.
- Escape from medical institutions without a discharge.
- Falsification of examination results and personal data in order to mislead doctors of other medical institutions.
- Tendency to travel, frequent changes of employment and residence.
- Tendency to use a large number of medications, sometimes narcotic substances [16].

In most patients, the existing symptoms are difficult to confirm with laboratory or radiographic studies. A patient can be proud of being a «medical secret» and misleading doctors. Any inconsistencies present, such as objective laboratory and physical findings that do not match the expected symptoms, should be noted. Additional clues to the diagnosis include a history of multiple hospitalizations, willingness to undergo medical procedures (even if they carry significant risk), history of frequent surgery, refusal of access to previous medical records, hostility to psychiatric intervention, overburdened clinical examination, inadequate response to standard disease therapy (for example, anemia not



resolved by blood transfusion), unusual course of the disease that the patient can predict, and new manifestation or exacerbation of symptoms when discharge is already inevitable [16].

It is important to distinguish Munchausen syndrome from a criminal conspiracy in which external gain is the primary motivation. In addition, it differs from conversion disorder in that patients with Munchausen syndrome deliberately falsify their condition for attention or a sense of significance. When differentiating Munchausen syndrome from other mental disorders, it should be remembered that such patients understand their disorder and realize that they are inventing their illness [7, 16].

Patients with Munchausen syndrome tend to deny the artificial nature of their symptoms, even when presented with some evidence of malingering. The diagnosis of Munchausen's syndrome exposes a person to dishonesty, then in a burning desire to prove himself right, he can seriously harm himself. Not receiving the expected attention to their «symptoms», they often become uncritical and aggressive. There have been reports of cases where patients, faced with their diagnosis, initiated legal proceedings; this may be caused by feelings of bitterness and resentment, and revenge against the clinicians. It's also a way to keep up your pretense in the courtroom after you're released from the treatment facility.

It was also concluded that various medical drugs, such as antidepressants and/or antipsychotics, have not shown sufficient efficacy in this condition. Those patients with co-occurring substance abuse, anxiety and depressive disorders have a more favorable long-term prognosis than those diagnosed with co-occurring personality disorders [16]. There are no drugs for the treatment of artificial disorders. However, medications can be used to treat any associated illness, such as depression or an anxiety disorder. Medications should be carefully monitored in people with delusional disorders because of the risk that such patients may use drugs to harm themselves.

If the doctor does not find a physical cause for the symptoms, or if he suspects that they may be self-inflicted, he will most likely refer the person to a psychiatrist or psychologist.

The treatment of Munchausen syndrome is also very complex and involves a great deal of tolerance on the part of the doctor and requires a strengthened alliance between the patient and the therapist to develop the patient's conscious self-control to minimize the feigned symptoms of the disease. Reports of successful treatment of such syndromes are limited [5].

When seeking treatment from a psychotherapist or psychiatrist, the first goal is to change a person's behavior and reduce their misuse of medical resources. Once this is achieved, treatment is aimed at addressing any underlying psychological problems that may be causing the person's atypical behavior. Another key goal is to help patients avoid dangerous and unnecessary medical diagnostic or treatment procedures (such as surgery).

Patients usually come to psychiatrists after long years of «wandering» to different specialists and clinics, after one of the doctors discovers a simulation, or, as is more often described in the literature, when the patient is exposed to self-harm by the medical staff of a medical institution. Munchausen's syndrome remains difficult to treat and, as a rule, causes a countertransference reaction in the members of the therapeutic team. At the same time, cases of self-deactualization of the disorder have been described in patients who underwent surgical interventions with severe, life-threatening complications in the pursuit of treatment [15, 16].

The main method of treatment of Munchausen syndrome is psychotherapy. Treatment is usually aimed at changing a person's thinking and behavior (cognitive-behavioral therapy). Family therapy can also be helpful: family members should learn not to support or encourage the behavior of the person with the disorder.

Two alternative management methods for patients with Munchausen syndrome have been described in the literature, and both are based on a psychological rather than a pharmacological approach. The confrontation strategy consists in providing the patient with such data that nullifies the possibility of their falsification. These can be blood tests or the results of other studies. Confrontational by definition, this approach should nevertheless be supportive and non-persecutive. Implementing this approach, the specialist emphasizes the patient's conviction that he is ill, needs treatment and will benefit from it. The patient engages in intentional and false representations of a psychiatric or general medical condition without evidence of abuse, and the behavior is independent of other medical or mental illnesses such as schizophrenia and delusional disorder. Direct confrontation of a patient with suspected Munchausen's disorder rarely leads to admission of the illness and instead usually ends in denial and even hostility [16]. In contrast, a non-confrontational approach is less concerned with etiology and is more focused on the consequences of the disorder and its subsequent control. Its purpose is to provide the patient with an opportunity for recovery without forcing him to evaluate the initial clinical picture as being simulated.

The standard treatment for all patients with suspected Munchausen syndrome is psychotherapy, although most patients refuse to see a specialist. In some cases, it may be helpful to focus cognitive-behavioral therapy on childhood traumas that may be causing the disorder. Instead, it may be more constructive for the physician to adopt an empathetic approach in which the patient is approached with support. It is imperative that psychiatry be involved (even if the patient is against it) to fully evaluate any other mental illness that may be present. It is not necessary for the patient to admit to their factitious disorder and, in fact, most patients rarely do. In certain cases, it may be helpful to target cognitive-behavioral therapy at the childhood trauma that may be the cause of the disorder [16, 17].

People with Munchausen syndrome are at risk of health problems or even death because they sometimes go too far in their attempts to fake the disease. The desire to prove to everyone that the disease is real forces a person to invent new ways to cause this or that symptom — often they are life-threatening. In addition, patients may suffer from reactions or health problems associated with multiple tests, medical procedures and treatments. They are also more prone to substance abuse and suicide. In addition, such people often abuse medical services. This can lead to the fact that the patient who really needs it will not receive help [17].

Although evidence for the most helpful intervention is lacking, the prognosis for Munchausen disorder is generally poor because few individuals are willing to admit their maladaptive behavior. Patients with comorbid substance use, anxiety, and depressive disorders have better long-term outcomes than those diagnosed with comorbid personality disorders [16]. Up to 30% of children who are exposed to a fabricated illness also have pre-existing medical conditions that can be worsened by the caregiver's fabrication. The mortality rate is 6–9%, and a similar percentage of children experience long-term health problems. Long-term psychological functioning of children who have experienced a caregiver-faked illness may be compromised by attachment problems, depression, anxiety, and PTSD symptoms. Additional psychosocial consequences for children may include poor academic performance and attendance, disruption of normal social relationships and activities, and social isolation. There is evidence that some older children and adolescents begin to engage in the deceptive behavior of the abuser [18].

Patients with suspected Munchausen syndrome present a difficult dilemma for the emergency physician. There are repeated

reports of the development of life-threatening respiratory failure in patients with Munchausen syndrome who required urgent tracheal intubation. In 1990, W.Z. Harrington and co-authors reported an «inadvertent interview» conducted with thiopental in a patient with overt respiratory failure as a manifestation of Munchausen's syndrome. At the same time, unnecessary intubation was avoided and the correct diagnosis was established [19, 20].

Unusual manifestations of this disorder have also been reported in the literature, such as delayed awakening from anesthesia, possible episodes of temporary apnea after regaining consciousness with a decrease in oxygen saturation up to 83%, subluxation of the temporomandibular joint, and vomiting. The diagnosis is usually made after all organic causes have been ruled out. Deterioration of the condition immediately after anesthesia has several causes, ranging from minor to several life-threatening diseases. Changes in physiological parameters or «vital signs» usually precede serious adverse events. Thus, the anesthesiologist must possess the acute acumen to quickly identify these changes, diagnose the pathology underlying them, and, if necessary, treat (or arrange for the treatment of) the pathological condition. It is necessary to consider several etiological factors that can delay recovery from anesthesia. These include residual effects of anesthetics causing impaired oxygenation and respiratory acidosis, electrolyte and plasma glucose disturbances, hypothermia, cerebral strokes (e.g. cerebral thrombosis/embolism, ruptured aneurysms) and seizures. Actual etiological factors that lead to decreased sensitivity after complete recovery from anesthesia primarily include hypoglycemia, hyponatremia, sudden cerebral pathology, and convulsions [21, 22]. False disorders cause unnecessary anxiety for treating physicians, wasting their time and health resources. Various manifestations of Munchausen syndrome and conversion disorder after uneventful anesthesia have been reported in the literature. A multifaceted strategy is needed to diagnose such cases. Additional information may also provide important diagnostic information. The pathophysiology of this disorder is not defined [21–24].

Patients with Munchausen syndrome [1] often undergo various surgical operations in different hospitals and receive a large number of drugs for anesthesia, which can contribute to the sensitization of the body to them. A unique feature of anesthesia is that short-term side effects may be unknown to the patient, but must be recorded in the medical records. Even if these reactions are known, such patients are quite reluctant to report them for fear of exposure. Thus, if a patient has had an anaphylactic or pseudoallergic reaction to anesthetic drugs, he is exposed to a significant/fatal risk of a fatal reaction, mostly with urgent surgical intervention without informing the anesthetist of previous dangerous events. For all patients who are scheduled for any type of anesthesia, it is important to obtain preliminary anesthesia documentation, which patients may intentionally conceal [23].

Anesthesiologists rarely encounter patients with Munchausen syndrome, and a much larger proportion of them are unknown. In part, this can be explained by the lack of time and desire to argue with ambitious patients who categorically refuse to consult a psychologist and psychiatrist and constantly threaten with complaints, statements to law enforcement agencies and generally behave in an unacceptable manner [2, 13, 16].

The authors observed one unconfirmed case of Munchausen syndrome. A 35-year-old woman, weighing 60 kg, who had a large number of relatives and acquaintances by profession, underwent numerous surgical interventions for acute and chronic paraproctitis, complicated by rectovaginal fistula, in various medical institutions of the region and the city of Kraina. The patient did not provide an extract from the medical documentation, referring

to the fact that she «lost it». He denies any history of allergic reactions. A complete examination did not reveal any pathological abnormalities, except for the atypical course of the underlying disease. She categorically refused spinal anesthesia. General anesthesia was performed intravenously: s. atropini 0.1% 0.5 ml, phentanyli 0.005% 2 ml, s. thiopentali natrii 1% 45 ml; maintenance of anesthesia: phentanyli 0.005% 2 ml, 1% 25 ml. The course of general anesthesia and corrective intervention was uneventful. Recovery of consciousness on the operating table. It was planned to transfer the patient to the ward. 20 min after the end of anesthesia, the patient developed suffocation of the mixed type, cyanosis of the lips, acrocyanosis. SaO₂ — 80%, blood pressure 120/80 mm Hg, heart rate — 76 beats for 1 min. The temperature in the armpit is 39.1°C. Forced ventilation by mask method with 100% oxygen was started, strong inhalation resistance was determined. An anaphylactic reaction was suspected, intravenously titrated s. epinephrini hydrotartrate 0.18% 0.5 ml, without effect. To ensure intubation of the trachea, s. sibazoni 0.5% 4 ml was administered intravenously. Resistance to ventilation stopped, the patient fell asleep, hemodynamic indicators are stable, SaO₂ — 98%. The temperature in the axilla after 25 minutes is 37.0°C. Spontaneous breathing, oxygen therapy through a mask, FiO₂ — 0.5. She was transferred to the intensive care unit. After awakening 2 hours later, the patient again demonstrated an attack of asphyxia, but without a significant decrease in oxygen saturation. In the postoperative period, the patient constantly expressed her dissatisfaction with the medical staff, the healing process went atypically poorly. Two weeks later, a repeat operation was planned, which was already performed under total intravenous anesthesia with muscle relaxation and mechanical ventilation with propofol with ataractics and narcotic analgesics. After the end of the operation, the patient with stable hemodynamic parameters was transferred to the intensive care unit on spontaneous breathing with atmospheric air through an endotracheal tube. Body temperature — 36.2°C, SaO₂ — 96%. After the patient fully woke up, 1 hour after the end of the operation, extubation of the trachea was performed, after verbal communication with the patient, after 15 minutes, the pattern of suffocation repeated completely identically as after the previous anesthesia. Mask ventilation with 100% oxygen and the introduction of an atarakt made it possible to stop the attack of suffocation and the development of hyperthermia. Anesthesiologists suspected Munchausen's syndrome, the patient was recommended treatment by a psychologist before discharge, for which they were «thanked» by a complaint to the regional health department, and the woman turned to another medical institution.

Thus, doctors are limited in the right direction of such patients without their personal consent to be treated by psychiatrists. For this reason, the majority of Munchausen syndromes remain undiagnosed.

Conclusions

1. The possibilities of diagnosing such a condition are significantly limited by the characteristics of the patients' behavior and the impossibility of forced psychiatric intervention. 2. People with Munchausen syndrome worsen their own health and that of their dependents.

3. Such persons create precedents for medical errors, conflict situations, complaints and lawsuits.

4. Patients with Munchausen syndrome are a hidden group at risk of serious anesthetic complications.

References

1. Asher R. (1951) Munchausen's syndrome. *Lancet*, 1(6650): 339–341. doi: 10.1016/s0140-6736(51)92313-6.

2. Glaser D. (2020) Fabricated or induced illness: From «Munchausen by proxy» to child and family-oriented action. *Child Abuse Negl.*, 108: 104649. doi: 10.1016/j.chabu.2020.104649.
3. Ferrara P., Vitelli O., Bottaro G. et al. (2013) Factitious disorders and Munchausen syndrome: the tip of the iceberg. *J. Child Health Care*, 17(4): 366–374. doi: 10.1177/1367493512462262.
4. Hamilton J.C., Eger M., Razzak S. et al. (2013) Somatoform, factitious, and related diagnoses in the national hospital discharge survey: addressing the proposed DSM-5 revision. *Psychosomatics*, 54(2): 142–148. doi: 10.1016/j.psym.2012.08.013.
5. Aadil M., Faraz A., Anwar M.J. et al. (2017) A Case of Munchausen Syndrome Presenting with Hematemesis: A Case Report. *Cureus*, 9(6): e1348. doi: 10.7759/cureus.1348.
6. Caselli I., Poloni N., Ielmini M. et al. (2017) Epidemiology and evolution of the diagnostic classification of factitious disorders in DSM-5. *Psychol. Res. Behav. Manag.*, 10: 387–394. doi: 10.2147/PRBM.S153377.
7. Prangenberg J., Aasly J., Doberentz E. et al. (2021) Factitious disorders in Germany—a detailed insight. *Forensic. Sci. Med. Pathol.*, 17(3): 431–436. doi: 10.1007/s12024-021-00395-9.
8. Evans R.L., Tew J.C., Yates G.P., Feldman M. (2021) Factitious Disorder (Munchausen Syndrome) in Plastic Surgery: A Systematic Review of 42 Cases. *Ann. Plast. Surg.*, 86(4): e1–e6. doi: 10.1097/SAP.0000000000002526.
9. Béarar A., Bouzillé G., Jégo P., Allain J.S. (2021) A descriptive, retrospective case series of patients with factitious disorder imposed on self. *BMC Psychiatry*, 21(1): 588. doi: 10.1186/s12888-021-03582-8.
10. Meadow R. (1977) Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet*, 2(8033): 343–345. doi: 10.1016/s0140-6736(77)91497-0.
11. Wittkowski H., Hinze C., Häfner-Harms S. et al. (2017) Munchausen by proxy syndrome mimicking systemic autoimmune disease: case report and review of the literature. *Pediatr. Rheumatol. Online J.*, 15(1): 19. doi.org/10.1186/s12969-017-0152-6.
12. Gomila I., López-Corominas V., Pellegrini M. et al. (2016) Alimemazine poisoning as evidence of Munchausen syndrome by proxy: A pediatric case report. *Forensic. Sci. Int.*, 266: e18–e22. doi: 10.1016/j.forsciint.2016.08.010.
13. Strehle E.M. (2023) From Munchausen syndrome by proxy to factitious disorder imposed on another: What's in a name? *Acta Paediatr.*, 112(10): 2032–2034. doi: 10.1111/apa.16915.
14. Moral Jiménez M.V., Melendi Mancebo J. (2023) Actitudes hacia el síndrome de Münchhausen por poderes. *Int. J. Psychol. Psychological Ther.*, 23(2): 161–173.
15. Lorenzo M.G., Pérez S.M., Palacín P.S. (2023) Fever of unknown origin. *Pediatr. Integral*, XXVII (5): 257–268.
16. Weber B., Gokarakonda S.B., Doyle M.Q. (2024) Munchausen Syndrome. In: *StatPearls Treasure Island (FL): StatPearls Publ.*
17. Tatu L., Aybek S., Bogousslavsky J. (2018) Munchausen Syndrome and the Wide Spectrum of Factitious Disorders. *Front. Neurol. Neurosci.*, 42: 81–86. doi: 10.1159/000475682.
18. Cardona L., Asnes A.G. (2019) Disclosure of caregiver-fabricated illness to a child: A team-based approach to communicating with pediatric patients. *Clin. Child Psychol. Psychiatr.*, 24(3): 494–502. doi: 10.1177/1359104518816122.
19. Harrington W.Z., Jackimczyk K.C., Seligson R.A. (1990) Thiopental-facilitated interview in respiratory Munchausen's syndrome. *Ann. Emerg. Med.*, 19(8): 941–942. doi: 10.1016/s0196-0644(05)81576-8.
20. Klaassen F.A., Schober P., Schwarte L.A. et al. (2007) Acute respiratory failure leading to emergency intubation: an unusual manifestation of Munchausen's syndrome. *Resuscitation*, 75(3): 534–539. doi: 10.1016/j.resuscitation.2007.06.001.
21. Jan R., Akhter N., al Sohaibani M., Bithal P. (2020) Dealing with Deception: Factitious Disorder Post Anesthesia. *M.E.J. Anesth.*, 27(3): 239–242.
22. Misal U.S., Joshi S.A., Shaikh M.M. (2016) Delayed recovery from anesthesia: A postgraduate educational review. *Anesth Essays Res.*, 10(2): 164–172. doi: 10.4103/0259-1162.165506.
23. Frater R.A., Lew J.K. (1987) Dangers of anaesthesia in Munchausen's syndrome. *Br. J. Anaesth.*, 59(11): 1472–1474. doi: 10.1093/bja/59.11.1472.
24. Perets Ye.V., Buchok Yu.S. (2019) Синдром Мюнхгаузена в протсесі отримання клінічних знань у студентів-медиків. XVII міжнародна науково-практична студентська конференція «Uzhhorod medical students' conference». *Uzhgorod*. 10–13 April 2019: 165–166.

Гарячка при синдромі Мюнхгаузена

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Анотація. Синдром Мюнхгаузена — навмисне вигадкування та продукування особою патологічних симптомів (штучної хвороби), що вважається психічним розладом, оскільки це пов'язано з серйозним емоційним напруженням. Такі особи ненавмисно або помірковано імітують різні хворобливі стани, зловживають лікарськими препаратами та неодноразово піддаються різним болісним методам обстеження й оперативним втручанням, що в результаті призводить до значного погіршення стану здоров'я. Визначають класичний варіант і синдром Мюнхгаузена через довіру (делегування), який стосується впливу аб'юзерів на власних дітей або залежних осіб. Можливості діагностики такого стану значно обмежені особливостями поведінки пацієнтів та неможливістю примусового психіатричного втручання. Такі особи створюють прецеденти щодо лікарських помилок, скарг та судових позовів. Пацієнти із синдромом Мюнхгаузена становлять приховану групу ризику серйозних анестезіологічних ускладнень.

Ключові слова: лихоманка, синдром Мюнхгаузена, лікарська помилка, ускладнення анестезії.

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