

Case Report

A Case of Munchausen by Proxy in a Syrian Refugee camp in Lebanon

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Abstract

As the Syrian conflict rages on, more and more innocent civilians are fleeing their homes in pursuit of safety. The numbers of Syrians refugees that have left their country encroaches on 5 million, more than a quarter of them in Lebanon. These families, and by extension their children, live in suboptimal conditions in Lebanon, as there are no formal refugee camps. Refugee status increases the risk of development of psychological and organic disorders. Our manuscript sheds light on the grim situation of Syrian families and children in Lebanon through a case of Munchausen Syndrome By proxy in a Syrian refugee family.

ABBREVIATIONS

MSBP: Munchausen Syndrome by Proxy; DSM-V: Diagnostic and Statistical Manual of Mental Disorders 5; MR: Magnetic Resonance; MRA: Magnetic Resonance Angiography; MRV: Magnetic Resonance Venography

INTRODUCTION

According to UN data, at the time of writing of this manuscript, Lebanon is the country with the second highest number of Syrian refugees after Turkey [1]. Seventy percent of the refugees in Lebanon are living below the poverty line on less than \$3.84 per individual per day. In addition, less than 40% of requested aid by the Lebanese government and humanitarian agencies has been made available to them [2]. The underfunded and overcrowded Syrian refugee camps make for poor living conditions and subsequently contribute to an increased incidence of psychological pathologies, among other diseases.

COURSE IN HOSPITAL

Our patient is a 20-month-old Syrian male refugee. His mother fled with him to Lebanon while his father was incarcerated in Syria. The patient first presented to our ophthalmology department on February of 2016 at 12 months of age for a chief complaint of right eye bleeding. History dates back to 8 months of age when the first episode of right eye bleeding occurred, followed by another episode at 9 months of age, and then again just before his initial presentation. In all three instances, right eye

bleeding occurred concomitantly with seizure activity. According to the mother, the bleeding episodes were self-resolving, lasted for few minutes (<5min), and produced fresh red blood. The description of the seizure activity that occurred with the right eye bleeding was compatible with a generalized tonic-clonic picture. The mother reported no trauma to his eye, no fever or rash, no foreign body insertion, and no appreciable change in vision or any ocular abnormality between episodes. He was seen by a pediatric neurologist prior to his presentation and was prescribed Levetiracetam that failed to control his seizures.

Left eye retinoscopy was unremarkable. Retinoscopy of the right eye revealed total retinal detachment and hemorrhage with no light perception. The eye was non-salvageable, and enucleation was performed at an outside hospital shortly after his initial presentation. The patient was next seen at our Emergency Department (ED) at 16 months of age with a similar chief complaint of left eye bleeding associated with seizure activity. Valproic Acid had been added to his Levetiracetam but his seizures remained uncontrolled. The physical exam and the presentation were concerning for cellulitis. A CT confirmed orbital cellulitis, and ceftriaxone and vancomycin were subsequently started. Of note, no seizure activity was witnessed in the ED despite the patient staying upwards of 20 hours, and despite the mother reporting an average of 3-5 seizures per day. The child was transferred to another hospital to finish the antibiotic course.

The final presentation was at 19 months of age for unresolved left eye bleeding associated with seizure activity. The child

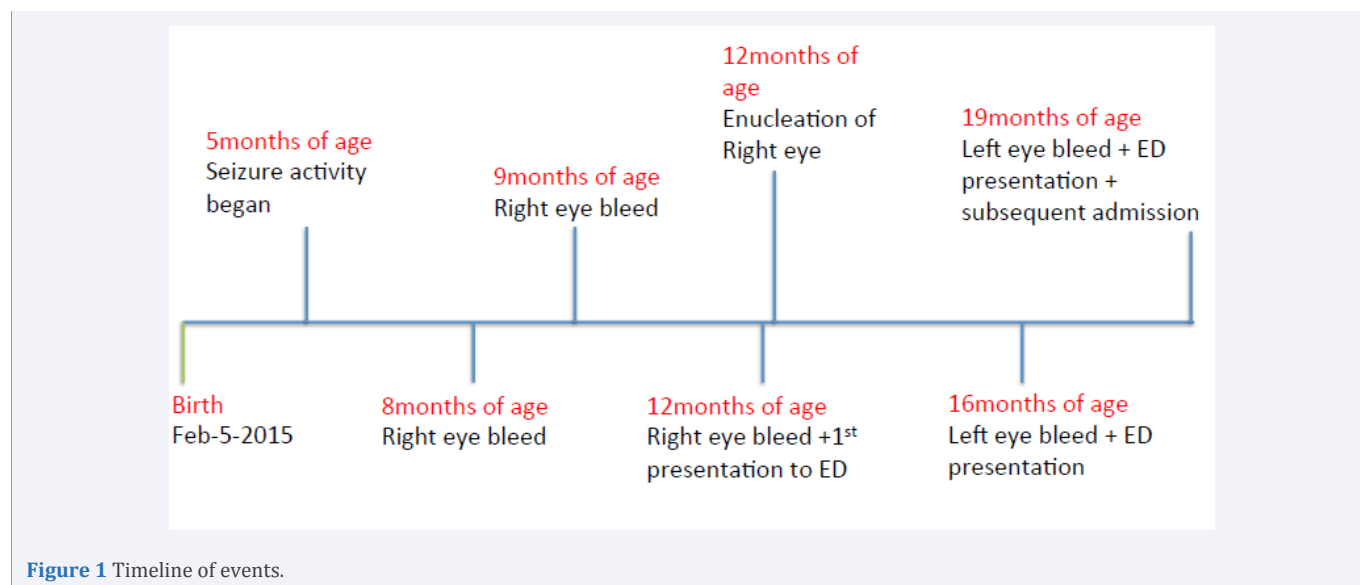


Figure 1 Timeline of events.

was admitted due to a concern of child abuse, and because an ophthalmology exam under general anesthesia was deemed necessary. Examination of the eye under anesthesia and different imaging modalities (MR with contrast, MRA and MRV) revealed severe inflammation and open ruptured globe with displacement of the lens. A video EEG recording was ordered to follow up on the seizure activity. The final recording revealed the mother pulling the curtains in front of the camera just before a muffled cry was heard and electrographic findings were recorded that were compatible with apnea leading to severe bradycardia and desaturation. The mother subsequently drew the curtains, and calmly called for a nurse to report that her child had suffered a "seizure episode". Refer to Figure 1 for timeline of events.

FINAL DIAGNOSES

Munchausen syndrome by proxy

DISCUSSION

The DSM-V classifies Munchausen syndrome by proxy (MSBP) as being part of the "Somatic symptoms and related disorders" under "Section II" of its new classification system. This disease, also referred to as Medical Child Abuse, occurs when a child is subjected to unnecessary and harmful medical procedures as a result of the caregiver's intentional misrepresentation or fabrication of symptoms.

The incidence of MSBP ranges from 0.5-2.8 per 100,000 individuals [3]. The perpetrator is most often the mother; with estimates of maternal MSBP ranging from 75-95% of all reported cases [4]. The abused child is often less than 4 years of age [6], and MSBP is usually diagnosed between the ages of 20-40 months [5].

Reported symptoms can be single or multiple and include fever, seizures, bleeding, vomiting, diarrhea, abdominal pain, and over 100 other symptoms that include almost every organ system [6]. Morbidity and mortality are difficult to assess because of the likely high incidence of cases never identified as MSBP. That being said, it is estimated that the mortality arising from MSBP ranges from 6-10% [4,6]. Morbidity is likely to be significantly

higher, especially when factoring in psychological effect of MSBP on the child.

The average length of time before diagnosis of MSBP is between 7.5 and 15 months [7]. In our patient, the length of time from first presentation to diagnosis was 6 months. Though this is below the average, the delay still resulted in loss of vision in our patient. Despite the unusual presentation, it was mainly the mother's ability to manipulate the staff's emotion that warded off strong suspicion of abuse. She used the humanitarian crises she had fled, the fact that her husband was supposedly detained, the poor conditions they were living in, and her status as a refugee to garner sympathy and support from the staff.

There is an abundance of literature regarding the susceptibility of refugees to psychological pathology including but not limited to MSBP [8]. It is likely that this higher susceptibility is due to more than just relocation, as higher incidences of psychopathology in refugees are well documented even when compared to non-refugee immigrants [9]. The increased susceptibility has been attributed to multiple causes that go beyond the immediate post-traumatic stress and include "marginalization, economic disadvantage, acculturation difficulties, loss of social support, and cultural bereavement" [8]. Refugee mental health outcomes were found to be related to several post-displacement factors including living conditions, economic opportunity, gender, resolution of conflict, repatriation, and pre-displacement characteristics. For example, individuals that belonged to a higher socioeconomic status pre-displacement fared worse, as did individuals who had a higher level of education. Individuals that sought refuge within their own countries fared worse than those who left the country altogether, and those who were housed in permanent quarters fared better than those who were placed in temporary accommodation. Gender was also found to be a risk factor for development of psychopathology, with females being at a higher risk when compared to males [8].

CONCLUSION

The poor living conditions that Syrian refugees suffer from in

Lebanon had a definite effect on the unfortunate outcome of our patient. At the age of 19 months, he lost vision in both eyes. The patient was placed in the care of an orphanage and the mother in custody. The absence of adequate infrastructure to relocate the refugees, the lack of funding to house them or provide them with proper medical attention, as well the disproportionately large numbers of refugees in Lebanon contribute to the problem at hand. More funding, greater man power, and additional efforts are required to provide the refugees with adequate standards of living as well as the necessary medical attention that this vulnerable population urgently needs.

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