

Recurrent Conjunctivitis as a Presentation of Munchausen Syndrome by Proxy

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Purpose: To report a case of Munchausen syndrome by proxy, which manifested as recurrent bilateral keratoconjunctivitis in an infant.

Design: Interventional case report.

Intervention: The patient underwent numerous diagnostic studies, including two endoscopies, skin biopsy, conjunctival pH measurement, and a skeletal survey. She underwent daily eye examinations until the corneal and conjunctival epithelial defects resolved.

Main Outcome Measure: Resolution of cutaneous, mucosal, corneal, and conjunctival epithelial defects.

Results: A punch biopsy of the right postauricular area was performed, and pathology subsequently determined that the findings seemed to be the result of an exogenous injury. The conjunctival pH was 8.0, consistent with exposure to an exogenous, caustic agent. The acute ocular lesions resolved.

Conclusions: Munchausen syndrome by proxy can be seen with ophthalmic manifestations and should be considered in the differential diagnosis when ocular abnormalities cannot be explained after a thorough and methodical evaluation. *Ophthalmology* 2003;110:1583–1585 © 2003 by the American Academy of Ophthalmology.

Munchausen syndrome by proxy is a manifestation of child abuse, which describes an infant or child who is seen, often repeatedly, with a disability or illness caused by an adult seeking secondary gain.¹ The purpose of this article is to report an unusual case with ocular involvement to prompt ophthalmologists to consider this diagnosis when a patient has ocular abnormalities that cannot be explained after a thorough and methodical evaluation.

Case Report

A 5-month-old infant first visited the emergency center of a large hospital for evaluation of “swollen eyes” and was diagnosed with viral conjunctivitis. The next day, she returned with worsening periorbital edema and erythema and was again given the diagnosis of viral conjunctivitis. She returned the next evening with a temperature of 101°F and was found to have a right otitis media and bilateral eyelid edema and erythema coupled with a copious, yellow ocular discharge from which cultures were obtained. Amoxicillin/clavulanate was prescribed for the otitis media. No organisms grew from the eye discharge cultures. Five days later,

the infant returned to the emergency center for the fourth time with worsened upper and lower eyelid edema, conjunctival injection, and punctate corneal erosions bilaterally. Ulcerations of the lower lip had also developed, and the patient was admitted with a tentative diagnosis of atypical Stevens-Johnson syndrome, presumed to be secondary to the amoxicillin/clavulanate. Topical steroids and systemic supportive therapy were initiated. Although her ocular and oral lesions demonstrated improvement in a timely manner with minimal supportive therapy, her hospital stay was extended for 3 weeks because of respiratory distress with stridor. At the time of discharge, her ocular and oral lesions had fully resolved, with only mild residual stromal scarring of the right cornea.

One day after discharge from the hospital, the infant returned with swollen eyelids accompanied by multiple lesions of the face and the oropharynx. Moderately edematous and markedly erythematous upper and lower eyelids (Fig 1) with multiple areas of crusting and ulceration with bleeding were noted. Interesting linear cutaneous erosions extended from the left lateral canthal area temporally toward the left ear (Fig 2), with similar lesions on the inferior aspect of the right ear. The pupils were 2 mm and sluggish to light with no afferent pupillary defect. Slit-lamp examination of the right eye revealed mild anterior stromal haze in the inferior aspect of the cornea, moderate conjunctival injection, chemosis, and a hemorrhagic membrane on the upper palpebral conjunctiva. Slit-lamp examination of the left eye demonstrated an epithelial defect overlying an area of stromal haze adjacent to the limbus inferotemporally with moderate conjunctival injection. The pH of the tear film was 8.0 bilaterally. The remainder of the ophthalmologic examination was unremarkable, and the child’s parents reported they had been with the child since the time of discharge.

In addition to the Ophthalmology service, Dermatology, Gastroenterology, Otolaryngology, Infectious Disease, and Allergy and Immunology were consulted. Many of these services were familiar with the patient, because they had been consulted during the previous hospitalization, and several began to suspect an unusual etiology because of the sudden reappearance of the muco-

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Figure 1. Edematous and erythematous upper and lower eyelids with multiple areas of ulceration and crusting.

cutaneous lesions immediately after hospital discharge, the atypical nature of the presentation, and the sparing of the nasal mucous membranes. Child Protective Services was contacted, and the infant was admitted to the hospital. An upper endoscopy demonstrated a fibrinous material covering the proximal and midesophagus with multiple erosions near the lower esophageal sphincter and within the fundus and antrum of the stomach, which were consistent with the ingestion of a caustic agent. A punch biopsy of the lesions in the right postauricular area revealed focal, coagulative necrosis of the epidermis with sparing of the basal cell layer, which, in the absence of vesiculobullous disease or a healing ulcerative process, indicated that the findings were the result of an exogenous source of injury. A skeletal survey was unremarkable. With minimal ophthalmic care consisting of 1% prednisolone drops and a lubricating ointment, the ocular lesions healed, and the child returned to baseline by the end of a 4-week admission. The child's mother later admitted to inflicting the injuries, but she did not disclose the identity of the agent used.

Discussion

Munchausen syndrome by proxy was first described as a form of child abuse by Meadow in 1977.² Munchausen syndrome by proxy is perpetrated in one of two ways: the caregiver either simulates or produces the illness in the child (in 25% of cases, both methods are involved). Simulated illness is defined as illness that is faked by the perpetrator but does not directly cause harm; whereas produced illness



Figure 2. Linear cutaneous erosions extend from the left lateral canthus toward the erythematous, desquamated auricular lobe.

is defined as illness that the perpetrator actually inflicts on the child. Rosenberg³ also found that 98% of the perpetrators were the biologic mothers of the victims. A preponderance of the mothers are described as amiable and socially adept, but saliently there seem to be themes of loneliness and isolation in many of their pasts. The most common psychiatric disorder noted is depression. Regarding the children involved, there is no predilection for either gender, and the mean age of victims at diagnosis is 40 months, with a mean duration of 15 months between onset of symptoms and signs to the time of diagnosis. The symptoms, signs, and laboratory findings of Munchausen syndrome by proxy span a wide spectrum, and the most common presentations include bleeding (44%), seizures (42%), central nervous system depression (19%), apnea (15%), diarrhea (11%), vomiting (10%), fever (10%), and rash (9%). We were unable to find any previously reported cases of ocular disease as the primary presenting sign of Munchausen syndrome by proxy in the literature. Two cases with ophthalmologic involvement have been reported. Feenstra et al⁴ described a case of chronic parotitis followed by orbital cellulitis caused by a probable injection of Alum by the child's grandmother. Wood et al⁵ described a case of fever of unknown origin with an associated anisocoria. Within the broader context of child abuse and nonaccidental injury, however, there have been rare cases of conjunctival and corneal injuries described in the literature. Taylor summarized them succinctly: two cases of inflicted corneal injuries—one bilateral and one unilateral⁶; recurrent keratoconjunctivitis in two siblings⁷; and a traumatic tarsorrhaphy secondary to cyanoacrylate glue in one eye.⁸

Esophageal erosions as a manifestation of Munchausen syndrome by proxy have been previously reported.^{9,10} Although noxious chemical agents have been used in previously described cases of Munchausen syndrome by proxy,^{11,12} to our knowledge this is the first case in which they were applied to the eyes.

It is imperative to recognize and confront Munchausen syndrome by proxy, not only to curtail the needless medical interventions and treatments, but more importantly because of its reported mortality rate of 9%.³ Munchausen syndrome by proxy can present with ophthalmic manifestations and should be considered in the differential diagnosis when ocular abnormalities cannot be explained after a thorough and methodical evaluation.

References

1. McClure RJ, Davis PM, Meadow SR, Sibert JR. Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Arch Dis Child* 1996; 75:57–61.
2. Meadow R. Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet* 1977;2:343–5.
3. Rosenberg DA. Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse Negl* 1987;11:547–63.
4. Feenstra J, Merth IT, Treffers PD. Een geval van het syndroom van Munchausen by proxy [A case of Munchausen syndrome by proxy]. *Tijdschr Kindergeneesk* 1988;56:148–53.

5. Wood PR, Fowlkes J, Holden P, Casto D. Fever of unknown origin for six years: Munchausen syndrome by proxy. *J Family Pract* 1989;28(4):391–5.
6. Taylor D. Unnatural injuries. *Eye* 2000;14:123–50.
7. Taylor D, Bentovim A. Recurrent nonaccidentally inflicted chemical eye injuries to siblings. *J Pediatr Ophthalmol* 1976;13:238–42.
8. Blinder KJ, Scott W, Lange MP. Abuse of cyanoacrylate in child abuse [letter]. *Arch Ophthalmol* 1987;105:1632–3.
9. Lansky SB, Erickson HM Jr. Prevention of child murder. A case report. *J Am Acad Child Psychiatry* 1974;13:691–8.
10. Lansky LL. An unusual case of childhood chloral hydrate poisoning. *Am J Dis Child* 1974;127:275–6.
11. Fleisher D, Ament ME. Diarrhea, red diapers, and child abuse: clinical alertness needed for recognition. *Clin Pediatr (Phila)* 1977;17:820–4.
12. Meadow R. Munchausen syndrome by proxy. *Arch Dis Child* 1982;57:92–8.