Short report

A neurosurgical Munchausen tale

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SUMMARY The travels of a young man feigning subarachnoid haemorrhage in London and Scotland, over the past year, are documented. The origins of the Munchausen Tales are reviewed.

Thirty one years have elapsed since the late Dr Richard Asher described the widely travelled patient with a dramatic and untruthful history, and dedicated the syndrome to Baron Hieronymus Karl Friedrich, Freiherr von Munchausen.¹ Asher suggested that the syndrome was common, and described three patients with abdominal Munchausen syndromes (laparotomophilia migrans). The majority of clinicians seldom encounter patients whose deception matches that of Asher's patients, and patients who simulate neurosurgical disorders are rare indeed.² "Stewart McIlroy" is perhaps the most famous patient of all.³ He found his way into many neurosurgical units (including Edinburgh) with the symptoms and signs of subarachnoid haemorrhage. Details of his case were widely published in the medical and popular press during 1979.⁴ We have now encountered a further neurosurgical case of the Munchausen syndrome in which the patient's history and signs closely resemble those of McIlroy.

Case history

AS said that he had been born on 19 March 1958, and described himself as a chef from London. He arrived in a taxi at Roodlands Hospital, East Lothian on an afternoon in April 1982. His story began at 3.00 am that morning when he woke with a severe headache that persisted for three hours. He got up to micturate and fainted, and on recovering consciousness he experienced hyperacusis and hyperaesthesia over the entire left side of his body. Examination revealed neck stiffness and weakness of the left arm and leg. Kernig's sign was asymmetrically positive on the left side and general examination was otherwise normal. He complained of such severe headache and photophobia

that he was given 2.5 mg of diamorphine and 50 mg of cyclizine prior to transfer to the Department of Surgical Neurology in Edinburgh. There he was found to be alert, apyrexial, and had a blood pressure of 150/100 mmHg. The visual fields were uniformly constricted, there was left sided hyperacusis, and hyperaesthesia of the whole of the left side of the face and body, crossing the midline of the trunk. Proprioception and vibration sense were absent at the left ankle, and there was a global grade 3 left limb paresis. Nuchal rigidity was mild and Kernig's sign could not be reproducibly elicited.

He spontaneously gave a past history of admission to Guy's Hospital, London in January 1982 with similar symptoms. He said that a lumbar puncture had shown blood stained fluid, and that he had undergone cerebral angiography and subsequently developed septicaemia. He had remained an inpatient for six weeks and his headache had persisted until March. It was not possible to trace his medical records at Guy's Hospital on the weekend of his admission to Edinburgh, however one of us (LMH) recognised him from a previous admission to Ninewells Hospital, Dundee.

It was decided to perform a lumbar puncture. This yielded clear CSF at a pressure of 110 mm, with normal glucose and cells and no growth on subsequent culture. The CSF protein was 0.86 g/l (normal range for our laboratory 0.2-0.6 g/l). The patient was discharged at the end of April 1982 after lodging verbal and written complaints concerning his "inadequate treatment".

Subsequent enquiries

He had indeed been admitted to Guy's Hospital in January 1982, giving a different name and address. His history was of severe headache and transient loss of consciousness, with three similar episodes in the preceding 18 months. Examination revealed tunnel vision and hyperaesthesia of the left side of his face and body. He had increased tone in his left arm and leg, but no weakness, and marked neck stiffness. Lumbar puncture yielded xanthochromic CSF at a pressure of 145 mm, with 26 red blood cells and 6 white blood cells, protein was 0.3 g/l. He developed retention of urine, was catheterised, and became pyrexial. His second

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lumbar puncture showed no organisms, but 19 000 red blood cells/mm³. After five days he was transferred to the Neurosurgical Unit at the Maudsley Hospital where a CT scan showed no abnormality. Bilateral carotid and right vertebral angiography were normal, but a staphylococcus albus had now been isolated from the second CSF specimen. A third lumbar puncture was then performed and showed 10 white blood cells/mm³, 4400 red blood cells/mm³, and a protein of 0.4 g/l. He was returned to Guy's Hospital after four days, and on removal of his urinary catheter he developed haematuria. He then developed a pyrexia of 43°C, and proteus was isolated from his urine and blood. He responded to intravenous antibiotics. Repeat angiography was planned but he declined this. After a week of bedrest he developed further headache and transient loss of consciousness. A fourth lumbar puncture revealed clear CSF at a pressure of 135 mm, with no cells and normal glucose and protein. He subsequently refused to mobilise and complained of great pain, whilst maintaining a benevolent smile. When a psychiatric assessment suggested that his symptoms were feigned, he miraculously mobilised and took his own discharge at the end of February 1982, complaining about his treatment. The following week he attended outpatients at St. Thomas' Hospital complaining of headache and was referred back to Guy's Hospital, but instead went to the Royal Free Hospital and presented on a Saturday with headache, vomiting, neck stiffness and left sided hyperaesthesia. A CT scan was performed and was normal, and he was transferred back to Guy's Hospital at the beginning of March where he stayed for two days before taking his own discharge.

Enquiries at Dundee revealed that he had presented there in July 1981, giving a Newcastle-upon-Tyne address, with an identical history. Neck stiffness was elicited, together with a left hemiparesis. Lumbar puncture and CT scan were normal, and a psychiatric opinion suggested a functional overlay. Following this discharge from Edinburgh in April 1982, he went to Aberdeen and on a Friday afternoon at the beginning of May 1982, he took a train to Inverness. Whilst on the train he developed an occipital headache and collapsed, and had to be taken off the train at Nairn, and admitted to Raigmore Hospital, Inverness. After transfer to the Royal Northern Infirmary, Inverness, no neurological signs could be elicited. He offered his past history of admission to the Maudsley Hospital, but gave the date of this as November 1981. He complained of headache and whole body hyperaesthesia and a lumbar puncture was performed which was normal. After a psychiatric consultation, he discharged himself.

Further enquiries revealed a similar drama on the Inverness to Aberdeen train on a Friday in November 1981. At Elgin station he developed a curtain across the right side of his visual field, and momentarily collapsed. He then noticed tingling in his left arm and leg and pain shooting from his fingers and toes to the back of his head. He collapsed again and was taken off the train at Inverurie, and then transferred to Aberdeen Royal Infirmary by a local general practitioner. Examination on admission to Aberdeen revealed a right homonymous hemianopia, hypoaesthesia on the right side of his face and anaesthesia in the left arm and leg. A lumbar puncture was normal, but his

severe headache persisted, and he threatened the medical staff with legal action. After a psychiatric opinion he was given some money by the medical social worker to assist with his passage South.

Discussion

We submit from the evidence of the history that we have been able to obtain, and from our own findings, that this patient can be considered to exhibit a neurosurgical presentation of the Munchausen Syndrome.

Baron Hieronymus Karl Friedrich, Freiherr von Münchhausen was born in 1720 and was a Cuirassier in the cavalry in the Russo-Turkish campaign in 1738.⁵ In 1741 he fought against the Swedes and was promoted to Captain, subsequently retiring in 1760 to his estate on the river Weser between Hanover and Cassel. He spent his time hunting and was a generous host. When entertaining friends he told of his travels and military and sporting exploits, often amusingly and absurdly embellished by his vivid imagination. His stories were told only to his circle of friends, and it is probable that Rudolph Eric Raspe was present on some occasions. Raspe was born in Hanover in 1737 and went to Göttingen University that had been founded by Gerlach Adolf von Münchhausen, cousin of the Baron. He read natural sciences and philology at University and was intelligent and ambitious, but always impecunious. In 1763 he published a work on volcanic geology that established his reputation as a scholar. He was appointed secretary of the State Library, and by 1767 was Councillor, Professor of Antiquity and Keeper of the Collection of Frederick II of Hesse-Cassel, (the son-in-law of George II). In 1769 he was elected a Fellow of the Royal Society in London. In 1774 he began embezzling medals in his charge in the collection at Cassel to maintain his extravagant mode of life. He was exposed and fled via Holland to England where he was expelled from the Royal Society but gained an appointment in the Assay Office in the North Cornish tin mines. It was here that he began composing stories of fantastic imaginary travels, drawing from such sources as Bebel's *Facetiae*, Castiglione's *Cortegiano* and Bildermann's *Utopia*,⁶ as well as his memories of Baron von Münchhausen. He published 17 tales in English, anonymously in 1785.⁷ These were very popular, and made his book a best seller. Further editions followed and were translated into German as well as most other languages, including Chinese.

Baron von Münchhausen was 65 when the poet Gottfried August Bürger's German translation of Raspe's book appeared,⁸ and the popularity of the book made him notorious, with sightseers constantly

disturbing his peace. Raspe's anonymity prevented the Baron taking any legal action, and he became embittered and died of a stroke in 1797. After 1785, Raspe had moved from Cornwall to London and then to Edinburgh where he catalogued the James Tassie medallion collection for the Scottish National Gallery, and had his own medallion executed by Tassie in 1791. The same year he became involved in a mining swindle on Sir John Sinclair's Estate and had to flee to Ireland, where he died of scarlet fever at Muckcross in Donegal in 1794.

The exploits of patients with Munchausen's syndrome barely match those of Rudolph Raspe, but our patient's catalogue of investigative procedures over the past 12 months begin to rival those of Stewart McIlroy, with at least seven lumbar punctures, three CT scans and three vessel angiography to his credit. He highlights the difficulties in diagnosis, with xanthochromic CSF in London, and a high CSF protein in Edinburgh, both probably the results of previous lumbar punctures. His arrival at an unsuspecting hospital on a Friday afternoon or Saturday, ensured that previous records are difficult to trace. His symptoms and signs bear an uncanny resemblance to those first used by Stewart McIlroy in 1954, with headache, photophobia, neck stiffness and a left hemiparesis being common features. It may be that he has copied McIlroy's technique after reading about his exploits in the popular press.⁴

The problems of management^{3,9} persist despite formal psychiatric consultations, and help from social workers and the Samaritans. AS will no doubt continue to perplex casualty officers and neurosurgeons in the years to come. Hounsfield's invention of the CT scanner¹⁰ will spare him the burr holes and ventriculography that McIlroy suffered,

and he is fortunate that exploratory craniotomy does not share the same vogue as exploratory laparotomy.

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