LETTERS TO THE EDITOR

A neurosurgical Munchausen revisited

In 1983 Henderson *et al* described a young man who was repeatedly admitted to hospital feigning subarachnoid haemorrhage. In at least two of the admissions he developed associated left sided limb weakness and he had undergone numerous investigations including repeated CT head scan, angiography and CSF examination.

In 1986 a patient with the same initials, date of birth and occupation was admitted to Guy's Hospital with a history of severe headache and left hemiparesis. The similarities to the previously published case were recognised and it became apparent that this was indeed the same patient. He was referred for a psychiatric opinion and was admitted for inpatient therapy for a period of two weeks with management following behavioural lines combined with group psychotherapy. There was an apparent improvement and the patient was discharged.

In June 1988 a patient with the same initials but slightly different date of birth was admitted to the neurosurgical ward at the Western General Hospital in Edinburgh with the acute onset of severe headache and left hemiparesis. He was recognised as being the same patient who was admitted to Guy's two years previously with Munchausen's syndrome and enquiry to the general practitioner revealed that there was a dossier containing details of 200 hospital admissions in the previous three years in the United Kingdom, Ireland, Belgium and Holland. The clinical presentation was always the same and the patient had undergone repeated investigation including CT scan and lumbar puncture.

The opinion from the psychiatrists was that the patient had aimed to completely deceive medical practitioners again on this admission and that he had no genuine motivation to accept any help that might be offered to try and modify his behaviour. The patient was therefore confronted, with an immediate resolution in the weakness so that he was able to leave the hospital ward stopping off only to collect money from the Social Work Department to enable him to travel home.

Two months ago the same patient was referred for a neurological opinion at the Western General Hospital for investigation of recurrent headache and hemiparesis. Before admission could be arranged the patient moved to Glasgow and has subsequently been admitted to the Chesterfield and North Derbyshire Royal Hospital with acute headache and hemiparesis which was promptly recognised as being due to Munchausen's syndrome. During this admission there was evidence of numerous admissions to hospitals in Glasgow, Liverpool and Peterborough and when confronted the patient made a rapid recovery and left hospital.

The purpose of this letter is to bring to the attention of general physicians, neurologists and neurosurgeons throughout the United

Kingdom of the existence of this patient with Munchausen's syndrome. The evidence suggests that he has repeatedly been admitted to hospital for investigation of acute headache and left hemiparesis and has undergone repeated radiological investigations and lumbar puncture. The frequency of these admissions is difficult to judge but it is of some concern that he has now attended the Western General Hospital on two occasions in the last three years, despite the fact that he knows he may be recognised.

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Henderson LM, Bell BA, Miller JD. A neurosurgical Munchausen tale. *J Neurol Neurosurg Psychiatry* 1983;46:437-9.

Rectal apomorphine: a new treatment modality in Parkinson's disease

In 1987 Stibe *et al*¹ reported the successful use of apomorphine to relieve "off period" symptoms in patients with response fluctuations during levodopa therapy for Parkinson's disease. Subsequent publications have confirmed their results.^{2,3} Stibe *et al* injected the drug subcutaneously or via an infusion pump, but recently Kapoor *et al*⁴ reported that intranasal application of apomorphine was as effective as subcutaneous injection, and suggested that it could become the route of choice.

We report on the results of rectal administration of apomorphine to three patients with severe response fluctuations to anti-Parkinson therapy. The drug was administered as an enema in a concentration of 10 mg/ml at the beginning of the "off period". All three patients had previously improved after subcutaneous or intranasal apomorphine. Informed consent was obtained before the start of therapy. Existing anti-Parkinson medication was continued unchanged.

The mean age of the patients was 65 years, the mean lapse of time since Parkinson's disease was diagnosed was 7.7 years, and the mean duration of levodopa therapy was 6.9 years. Motor disability was assessed using the Columbia Rating Scale and by quantitative measurement of walking time, hand tapping and foot tapping, and pinboard testing as described by Lees *et al*.⁵ Pharmacokinetic data (C_{max} and T_{max}) were obtained from blood samples taken at short intervals after the enema was administered.

The first patient showed no motor response to 10 mg apomorphine, although substantial plasma levels were shown. (T_{max} 9 minutes, C_{max} 7 ng/ml). Previously 5 mg apomorphine subcutaneously had been sufficient to relieve "off period" akinesia. Increasing the rectal dose to 25 mg, however, had a beneficial motor effect equivalent to that obtained with a subcutaneous dose of 5 mg. T_{max} was 15 minutes and C_{max} 19 ng/ml.

The second patient, known to respond positively to 3 mg apomorphine subcutaneously, showed an equivalent motor response to 15 mg rectally. T_{max} was 15 minutes and C_{max} 14.6 ng/ml. The duration of response was 35 minutes with a latency of onset of 15 minutes.

The third patient, previously experiencing optimal benefit from 4 mg apomorphine intranasally, demonstrated a positive motor response to 10 mg rectally (fig). When 20 mg was given rectally, motor improvement was longer lasting, (60 minutes against 18 minutes), but was accompanied by slight though not disabling dyskinesias.

In our three patients, apomorphine appeared to be as effective in the relief of "off period" signs and symptoms when given rectally, as it was by the subcutaneous or intranasal routes. The effective dose, however, was two and a half to five times greater. Recently Hughes *et al*⁶ reported their experience with high dose (200 mg) apomorphine suppositories. In our experience an enema has a much shorter latency of onset than a suppository, which suggests that it would be more useful for patients suffering frequent "off period" symptoms. The clinical effect was, however, also of much shorter duration

Figure Plasma apomorphine concentrations in the third patient after rectal application of 10 mg (—) and 20 mg (---) apomorphine. The motor response is shown in the upper bar for the 20 mg dose and in the lower bar for the 10 mg dose.