cases occur in children over the age of 6 years.[2] We present a case of 3 siblings aged 5, 8, and 11 years who were victims of this syndrome.

A 38-year-old female presented to us for evaluation of her children; 2 daughters (11 and 8 years) and a 5-year-old son. All of them had a history of blistering followed by scarring on the nose and cheeks since early infancy. According to her, all children developed redness and blisters on the nose in their second year. The lesions subsided leaving behind scarring. There was no history of consanguinity, photosensitivity, growth, or mental retardation. There was no family history of similar presentations or any other genodermatoses. The children had been taken to various hospitals over the last few years, were investigated (biopsied 2-3 times), and were treated with multiple creams, but that did not improve the scars.

On examination, all 3 children only had post-inflammatory hyperpigmentation and scarring on the nose extending to the sides. [Figure 1] A review of all the investigations and histopathology was inconclusive. It was explained to the mother that since the lesions were non-progressive and no new lesions appeared, so surgery and laser for scarring could be performed later. The mother was not convinced and insisted on more investigations. One month later, she presented with the youngest child who had mild erythema and scaling on the lesions over nose and insisted on repeating the biopsy. The indifferent behavior of the mother and children and her eagerness for investigations prompted us to get a psychology consultation.

After much persuasion, she agreed for the psychology

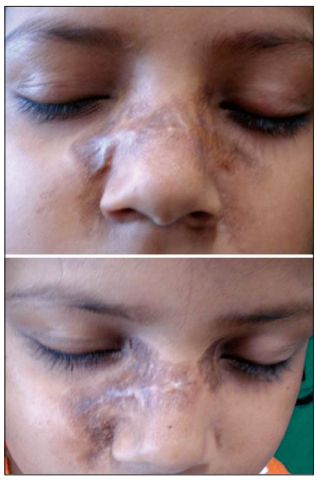

Figure 1: Hypertrophic scarring on the nose

Munchausen by proxy in a family

Sir,

Munchausen syndrome by proxy (MBP) is a term used for a specific behavior, in which a parent or a guardian deliberately exaggerates, fabricates, or induces physical or psychological symptoms in a child.[1] In literature, MBP has mostly been reported in very young children; however, approximately 25% of the

consult, and she was diagnosed with moderate depressive disorder. She was not happy with her marriage and felt overworked and ignored. On further questioning, she confided that she felt lonely due to the distant relationship with her husband who was in army and used to visit them very infrequently, and she also suspected infidelity. The mother did not exhibit any signs of childhood abuse or neglect.

MBP was confirmed when she confided that she had burnt her children's faces with hydrochloric acid, used as a toilet cleaner. The frequent visits to the doctors satisfied her hidden need for attention. She did not allow the lesions to heal and would often apply the acid again. Father was taken into confidence and psycho-educated about the diagnosis. She was directed to the psychologist for cognitive behavior therapy sessions.

Child abuse is a serious problem in the West, but it is still considered a rare entity in India. However, a study evaluating child abuse in India reported 69% of the 12,000 respondents had history of physical abuse.[3] MBP is a rare form of child abuse that is often unrecognized and under-diagnosed in our setup.

Munchausen syndrome is the most severe and chronic form of dermatitis artefacta. When the perpetrator feigns symptoms and signs in a child, the condition is called Munchausen syndrome by proxy. Currently, the preferred term is pediatric condition falsification for the child or factitious disorder by proxy for the perpetrator.[1]

There are numerous reasons for the delay in the correct diagnosis of MBP. First, nobody suspects that a parent would harm their child because the perpetrators appear as devoted parents. In their desire to help the victim, physicians often do extensive work-up for rare diseases, with which may detract from the real diagnosis and facilitate the perpetrator's manipulations.[4] Prolonged and multiple hospitalizations can cause complications such as nosocomial infections, which further complicate the picture. Children may not be able to speak up for fear of affecting their relationship with the parent. All these result in long-standing abuse, resulting in aggression, depression, anxiety and alcohol or drug abuse in the children. Subsequently, the victims may also become perpetrators themselves.[4,5]

The most important reason for missing the diagnosis of a factitious disorder is failure to consider it. Warning signs to alert one to consider this diagnosis include: An unusual illness/ symptom that cannot be fully proven despite multiple prior consultations, the child appears too well to fit the history and frequent treatment failures. The profile of the perpetrator has been described as intelligent, articulate, and medically sophisticated. They invariably have some physical or mental problems and history of marital discord. Studies have shown that, in more than 90% of the cases, the mother is the abuser.[6,7]

Apnea and seizures are the two common presenting complaints in MBP.[4,6] The skin may be burnt, lacerated / punctured, dyed, or tattooed to simulate any acute or chronic skin condition. The intent in MBP can be quite variable and is not fully understood. It could be an attention seeking behavior, a need to be in the limelight, be recognized as a devoted parent, or relationship with the doctor by using the child as a vehicle.[5] Occasionally, it may be a manifestation of a compulsive behavior to deceive the doctor in his area of expertise and even derive gratification out of it. Our case fits into the first scenario, the motive here being to bring her husband back to live with them.

Psychiatrist's involvement is essential for evaluating the exact motivation of the perpetrator, but it should be done without confrontation or arousing suspicion. The proxy / child requires no active treatment, except separation from the perpetrator. The difficult part is convincing the perpetrator that he needs therapy. Psychotherapy, in the form of behavior modification, focused social case work, anger management, desensitization and family therapy, are the mainstay of therapy.[6,7]

In our setup, legal options regarding MBP are not well defined as in other countries. Legal involvement may be stigmatizing for the family and the children. If the injury is mild, then best approach is informing and involving other family members. The golden rule in such cases is avoiding confrontation, try to build a strong rapport with the perpetrator and motivate him/ her to begin psychopharmacotherapy. If the patient poses an acute threat to himself or others, and if there is no motivation for therapy, childcare agencies can be involved; it may be necessary to admit the patient to a psychiatric ward after consultation with a psychiatrist and with the legal assistance of the court system.

There is a scarcity of reports of cases of MBP in the dermatology literature although dermatologists are often involved in the evaluation of such cases. Management of such cases begins with awareness and considering the diagnosis of MBP and subsequently multidisciplinary team effort involving health professionals and experts from various departments, social workers, and law enforcement authorities.

Tarun Narang, Amrinder Jit Kanwar, M. Sendhil Kumaran, Shubh Mohan Singh[1]

Departments of Dermatology, Venereology and Leprology, and [1]Psychiatry, Post Graduate Institute of Medical Sciences and Research, Chandigarh, India

Address for correspondence: Dr. Tarun Narang, Department of Dermatology, Venereology and Leprology, Post Graduate Institute of Medical Sciences and Research, Chandigarh, India.
E-mail: narangtarun@yahoo.co.in

REFERENCES

1. American Psychiatric Association (APA). DSMIV- TR: Diagnostic and statistical manual of mental disorders. Washington, DC: APA; 2000.
2. Sheridan MS. The deceit continues: An updated literature review of Munchausen syndrome by proxy. Child Abuse Neglect 2003; 27:431-51.
3. Kacker L, Varadan S, Kumar P. Study on Child Abuse: India 2007. New Delhi: Ministry of women and child development, Government of India; 2007. p. 44.
4. Galvin H K, Newton AW, Vandeven A M. Update on Munchausen syndrome by proxy. Curr Opin Pediatr 2005;17:252-7.
5. Rand DC, Feldman MD. An explanatory model for Munchausen by proxy abuse. Int J Psychiat Med 2001;31:113-26.
6. Leonard KF, Farrell PA. Münchausen's syndrome by proxy. A little-known type of abuse. Postgrad Med 1992;91:197-204.
7. Meadow R. Munchausen syndrome by proxy, the hinterland of child abuse. Lancet 1977;2:343-5.

Access this article online	
Quick Response Code:	Website: www.ijdvl.com
	DOI: 10.4103/0378-6323.102377