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Fictitious Epilepsy associated with Amnesia

Epilepsy can occur in patients without any changes apparent in the electroencephalogram. Thus the diagnosis of epilepsy is essentially made on clinical grounds. The clinical features of epilepsy are relatively easy to learn to mimic. Feigned epilepsy can occur in adulthood or it may occur in childhood, as part of a Munchausen syndrome by proxy as described by Meadows (1984). We would like to describe a case of feigned epilepsy with global amnesia, and several other symptoms of aberrant illness behaviour.

Case report

A woman of 30 years of age was admitted to the Royal Liverpool Hospital on 26 September 1984, brought to the Accident and Emergency Department via the Samaritans. She claimed that she had lost her memory, and alleged that she could not remember her name or any of her personal details. She said that she thought she was an epileptic, and in her handbag were bottles of anticonvulsants. Ward observers noted fits, some of which appeared genuine. Neurological examination following one such fit revealed weakness of the sixth cranial nerve and decreased sensation and weakness of the right side. Phenytoin and phenobarbitone were recommenced, and a Heminevrin infusion given for 6 days. Liver function tests revealed after 2 days raised liver enzymes: gamma-glutamyl transferase = 290 U/l (NR 0–65) and alanine amino transferase = 54 U/l, (NR 7–54). These continued to rise for 6 days to 580 and 280 U/l respectively, before gradually decreasing. She had a swinging pyrexia, and because of a history of a mastoidectomy, an ENT surgeon examined her, and prescribed antibiotics. An EEG and a repeat EEG showed no abnormality. Later she was seen holding a lighter near a thermometer. Suspicion was raised as to whether she was feigning illness and she was transferred to a psychiatric ward on the 18 October 1984.

She revealed that she had been a patient at the North Manchester General Hospital, and subsequent enquiries revealed she had been admitted there under the care of a physician in July 1984, and had only been discharged 7 days prior to her admission in Liverpool. The history then had been a very similar one of amnesia and epilepsy. As a result of her non-response, she had been prescribed an escalating dosage of phenytoin and had developed phenytoin toxicity. The character of her epilepsy was later thought to be feigned and some of the fits responded to placebo treatment. Numerous investigations including EEGs, a CAT scan and lumbar puncture proved negative.

Following extensive enquiries the following details of her personal history were obtained. She was born in Blackpool in 1954. Her father was a greengrocer, and she was their only child. She was enuretic until the age of 10 years and truanted from school. She left school at 15 and followed

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a pre-nursing course for one year. Her first child was born when she was 17. She married a soldier, but the marriage only lasted one year, and her second child, a boy, was born then. She worked over a long period as a taxi driver. She lived with her parents until 1980 and was drinking heavily. She had frequent contacts with the local hospital and attended various clinics, including ENT and gynaecology clinics. In 1980 she was admitted to a hospital in Blackpool following an overdose of alcohol and drugs. In November 1980 she was admitted to Lancaster Moor Hospital with a history of amnesia. Since 1980, when she left home, she has had numerous admissions to hospitals in Preston, Bolton, Leeds, Bradford, Chester, Rochdale and Manchester. She has used various names and had numerous investigations for her amnesia and fits. These include several EEGs, CAT scans, X-rays, blood tests, and lumbar punctures. These have shown no abnormality except for raised liver enzyme levels on some occasions. She is also known to have had five convictions, and was in Risley Remand Centre as recently as April 1984. At the time of her admission she was still on probation.

On admission to our unit, mental state examination revealed that her affect was bland and she appeared unconcerned about her memory loss. Formal testing of her short-term and long-term memory showed them intact. However she continued to maintain that she did not know her name or any of her personal details, except the odd titbit, e.g. she could remember being in a car accident, and that she had been divorced. There was no other cognitive defect or other evidence of mental illness. The nursing staff observed her to have some 'fits' — some of which appeared genuine, and at times she bit her tongue and was incontinent. On 24 October 1984 she presented the nursing staff with a sample of apparently blood-stained urine which she claimed to have voided. No physical cause of haematuria was found. On 19 November 1984 she went to the hospital's Casualty Department, giving a fellow patient's address. She complained of chest pain and an ECG was performed. She was on the point of being admitted to a medical ward, when she was discovered.

She was discharged on 19 December 1984 to a probation hostel in Liverpool. A few days later, on New Year's Eve, she again presented herself to the Casualty Department complaining of chest pains and haemoptysis. She was admitted to a medical ward with a suspected pulmonary embolus and heparin therapy commenced. When her identity was discovered a few days later she was discharged.

Comment

This case shows many of the typical features of a Munchausen syndrome (Enoch & Trethowan, 1979). The patient appears to be in an early phase of her career as a hospital addict; the best documented case so far being McIlroy (Pallis & Bamji, 1979). Although Munchausen Syndrome cases usually present with physical complaints, 'psychological' Munchausen Syndrome cases do exist as shown by feigned bereavements (Cremona-Barbaro, 1983). This case shows the co-existence of physical and psychological symptoms. The only physical abnormality found in this case were the raised liver enzyme levels. These findings are difficult to explain, but could be related to liver damage due to her past alcohol abuse, a recent bout of heavy drinking, or a paracetamol overdose such as she has taken in the past.

Management of Munchausen syndrome cases is extremely difficult, as it depends on the patient's motivation, which is usually concerned with more 'treatment' — they seek the mode of cure rather than the cure itself. It has been suggested that local casualty departments should be informed of such cases to aid in their detection. One possible solution is the setting up of a register, and with modern technology it would be relatively simple to keep a national database of such cases on a micro-computer.

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Ephedrine Psychosis Rediscovered

The use of ephedrine for medicinal purposes dates back over 5000 years, when native Chinese physicians first used a herb, Ma Huang, which contained the active alkaloid. Ephedrine was extracted from

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