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Sir,

Factitious keratoconjunctivitis (not another case of ocular Munchausen's syndrome)

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We report the case of a young female patient who self-induced a chronic keratoconjunctivitis by inserting tissue paper and cotton wool into her conjunctival fornices.

Case report

A 17-year-old woman was referred to our outpatient department with a 2-month history of left conjunctivitis and mild periorbital oedema. Initial unaided visual acuities were 6/9 in each eye. Right ocular examination was normal. Left ocular examination revealed intense papillary conjunctivitis, mainly involving the inferior tarsal and bulbar conjunctiva, with multiple punctate erosions of the inferior cornea (Figure 1a). Mild left periorbital oedema and a mucous discharge were also present. There were no prior ophthalmic problems. She suffered from hay fever and worked in a factory as a fish processor. Our initial differential diagnosis included allergic, toxic, or infective conjunctivitis.

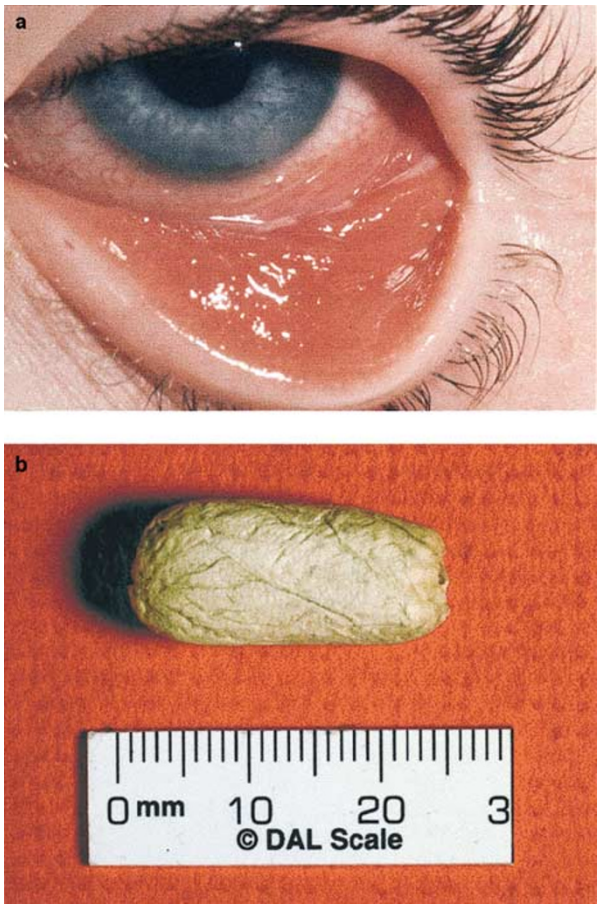

Figure 1 (a) Inferior keratoconjunctivitis (lid held down by photographer). (b) Tissue paper foreign body.

In the following 2 months repeated conjunctival swabs were negative for bacteria, viruses and chlamydia. Despite courses of topical steroids and antibiotics (both preserved and unpreserved), and a trial of systemic erythromycin, her conjunctivitis persisted and inferior corneal subepithelial infiltrate with neovascularisation developed. Conjunctival biopsy showed changes of chronic inflammation only. Her full blood count, urea and electrolytes, serum immunoglobulins, C-reactive protein and autoantibodies were all normal.

One month later her left keratoconjunctivitis improved but she developed identical signs in her right eye.

Fluctuating keratoconjunctivitis continued for the next 4 months, affecting one or the other eye, independent of treatment with topical steroids, antibiotics, or antivirals.

Seven months following presentation, she was admitted to our ward for observation after small pieces of cotton wool were noticed in the left conjunctival fornix. During her admission, large pieces of neatly folded tissue paper (Figure 1b) were found on several occasions in her conjunctival fornix and factitious disorder was diagnosed. While *in situ* these objects caused significant lower lid ectropion. When we suggested that she was inserting the tissue paper, she denied this and stated that the tissue paper and cotton wool must have been accidentally inserted during routine eye cleaning. After this discussion, she often quickly removed tissue paper from her fornix whenever medical staff entered her room. During her admission she was shy and nervous but never uncooperative.

Psychiatric evaluation did not reveal a coexisting psychiatric or personality disorder. She had attended a special school because of reading difficulties but her intelligence was assessed to be within the normal range. Her parents had divorced 5 years previously and she lived with her mother and mother's boyfriend. She had few friends but was close to her mother and grandmother.

After the diagnosis of factitious disorder was made, her grandmother bought flannel cloths for cleaning her eyes and stopped her using tissue paper or cotton wool. Four weeks after discharge from our ward there was a dramatic improvement in her condition, with minimal conjunctivitis in either eye and resolving corneal infiltrate and new vessels.

Comment

Factitious disorders involve the intentional production or feigning of physical or psychological signs or symptoms. The motivation for the behaviour is to assume the sick role and external incentives for the behaviour are absent.[1] Munchausen's syndrome is a severe subtype of factitious disorder, first described by Asher in 1951, and named after Baron von Munchausen, a retired German cavalry officer who travelled widely recounting dramatic and untruthful stories.[2] The ophthalmic literature has sometimes used the term Munchausen's syndrome synonymously with factitious disorder,[3,4] but its use should be reserved for patients who have attended many different hospitals with extravagant and false stories. The distinction is important, as patients with simple factitious disorder sometimes remit spontaneously, whereas Munchausen patients typically have an unremitting course of injury and hospitalisation.[5]

Diagnosis of factitious disorder is notoriously difficult because deception and denial are integral features of the condition. In ophthalmic practice, suspicion should be aroused when the more accessible inferior and nasal aspects of the eye are primarily affected,[6] as in our case.

Once the diagnosis of factitious disorder is confirmed, the patient should be confronted in a supportive manner that redefines the patient's illness from a physical disease to that of a psychological stress.[5] Involvement of psychiatric services, the general practitioner and family members are essential at this stage. Behavioural therapy seeks strategies that allow the patient to save face while relinquishing their symptoms. Family intervention encourages family members to provide more attention to the individual and less attention to the disease symptoms.[5] Intuitively, our patient's grandmother successfully adopted both approaches by substituting flannel clothes for tissue paper and increasing her contact with the patient.

Our patient had several risk factors for factitious disorder, including an unsettled family life, repeated bullying at school and a limited framework of friends.[5] A case of ocular Munchausen syndrome induced by incest has been reported,[7] however, extended interviews with the patient, her mother and grandmother failed to identify a specific underlying cause.

Worryingly, a patient with ocular Munchausen syndrome showed initial improvement after diagnosis, only for her symptoms to return with the ultimate loss of one eye.[8] Our patient does not meet the criteria for Munchausen syndrome, and although her symptoms had not returned at the time of writing, there is no way to predict her future behaviour.

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Sir,

Preseptal cellulitis in systemic onset Juvenile Idiopathic Arthritis

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The aetiology of preseptal cellulitis is infective in the majority of cases. Systemic juvenile idiopathic arthritis (JIA), previously known as 'Still's disease', is a variety of childhood arthritis with rare eye involvement. We report a case of systemic onset JIA associated with bilateral preseptal cellulitis, the clinical course of which paralleled the systemic condition suggesting that the underlying pathogenesis was of noninfectious inflammation.

Case report

A 10-year-old girl presented with a 1-week history of a painful right knee and restricted mobility 7 days after developing an ear infection which had been treated with oral amoxycillin. This settled and she then developed swelling around her left eye, general malaise, and a high fever. The left knee became progressively more painful, and 1 day prior to admission her left elbow became swollen and tender. Her past history was unremarkable and there was no significant family history.

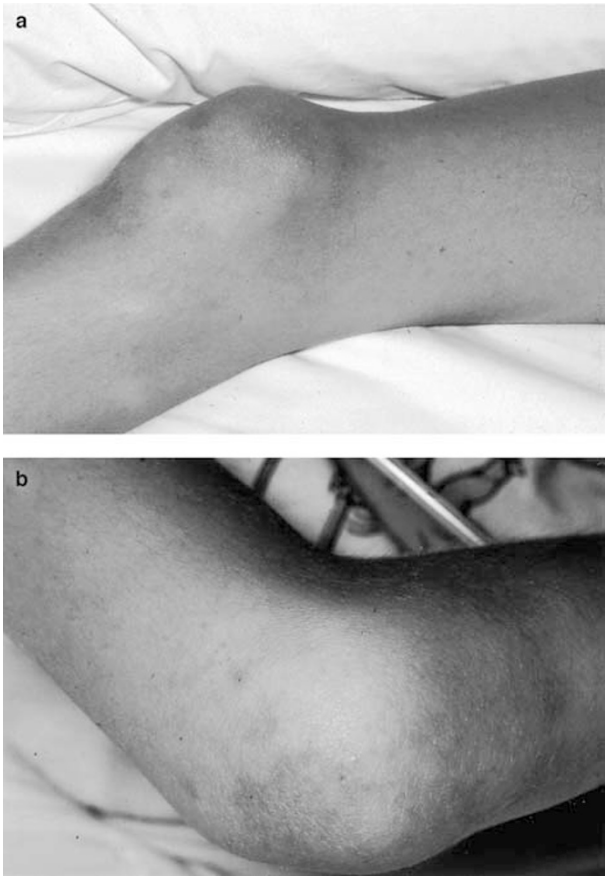

Figure 1 (a) Appearance of right knee joint swelling. (b) Appearance of left elbow swelling and receeding rash.

On admission, she was unwell with a pyrexia of 39°C. Examination of the orbits showed left-sided periorbital erythema and oedema but no proptosis and normal ocular movements. The right side was normal. Visual acuity was recorded at 6/6 in both eyes and there was no colour desaturation or afferent pupillary defect. The anterior segments were normal and fundoscopy showed healthy optic discs. Examination of her joints revealed a tender swollen left knee (Figure 1a), which was held in flexion, and a swollen painful flexed left elbow (Figure 2b). The other joints were normal. She was noted to have an ejection systolic flow murmur at the left sternal edge and abdominal examination revealed hepatomegaly but no splenomegaly. The rest of the examination was normal.

A full blood count showed the haemoglobin to be 10.6 g/l, platelets 697×10^9/l, and white cell count 21.4×10^9/l (17.5×10^9/l polymorphs). The erythrocyte sedimentation rate (ESR) was 90 mm/h. Blood cultures and bacterial swab of the left eye were negative. Aspiration of the left knee and left elbow revealed 3+ white cells in the synovial fluid with no organisms on