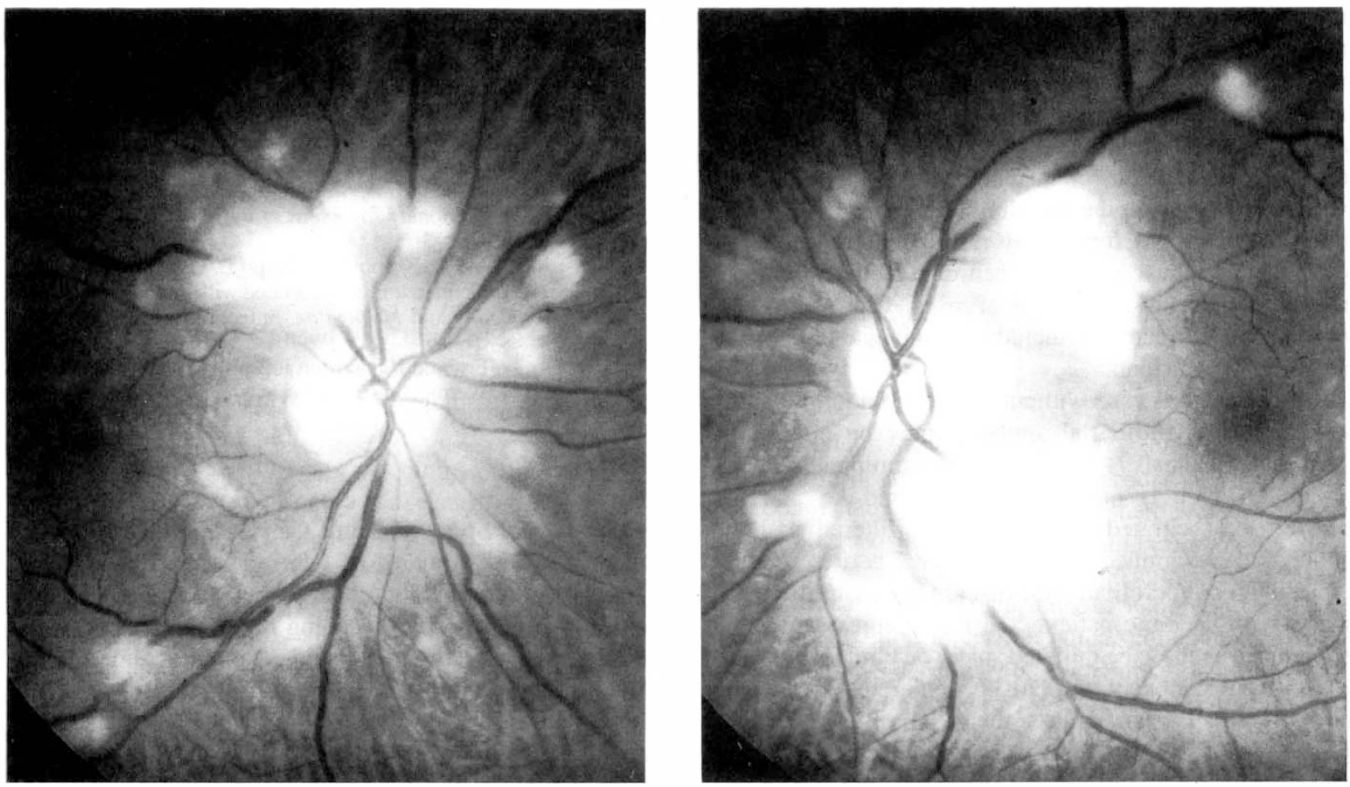

(a) (b)

Fig. 1. *Fundal photographs of right (a) and left (b) eyes showing striking cotton-wool spots but normal vessels and optic discs.*

Discussion

Ocular morbidity in giant cell arteritis is usually due to ischaemic optic neuritis,[1,2] caused by involvement of the short posterior ciliary arteries.[3] The proximal central retinal artery, which contains elastic tissue, may also be involved, sometimes as far as its branches.[3] As it runs from the ophthalmic artery to the globe there is a progressive reduction in elastic tissue and the extent of involvement may reflect this. It has been suggested that in 10% of cases of central retinal artery occlusion the cause is occult giant cell arteritis.[4]

Cotton-wool spots have been previously described in this condition, but in association with disc oedema.[1] Our patient was unusual in manifesting cotton-wool spots in the presence of clinically normal optic nerves. This was presumably due to an unusual pattern of involvement, sparing the short posterior ciliary arteries while reducing flow in the retinal circulation. The case underlines the clinical diversity of this disease.

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Sir,

Ophthalmic Munchausen's Syndrome

The essential features of Munchausen's syndrome[1] are that the patient travels widely with elaborate stories. The patient described here may be familiar to many, yet he continues to travel from hospital to hospital, often without his deception being detected, taking advantage of the fact that staff change frequently. He obtains board and lodgings and is the subject of costly and extensive investigations. The fact that he has recently visited St. Bartholomew's Hospital, London, for the fourth time has alerted us to his continuing activity. We believe that it is in the interest of the National Health Service that this case should be recognised by as wide an audience as possible.

Description

A 55-year-old man was referred to the ophthalmology department of St. Bartholomew's Hospital by the neurologists for an opinion about his abnormal eye movements and diplopia.

The patient described a piston-like explosion in the back of his head which occurred while he was travelling on a train. He immediately lost consciousness for what he

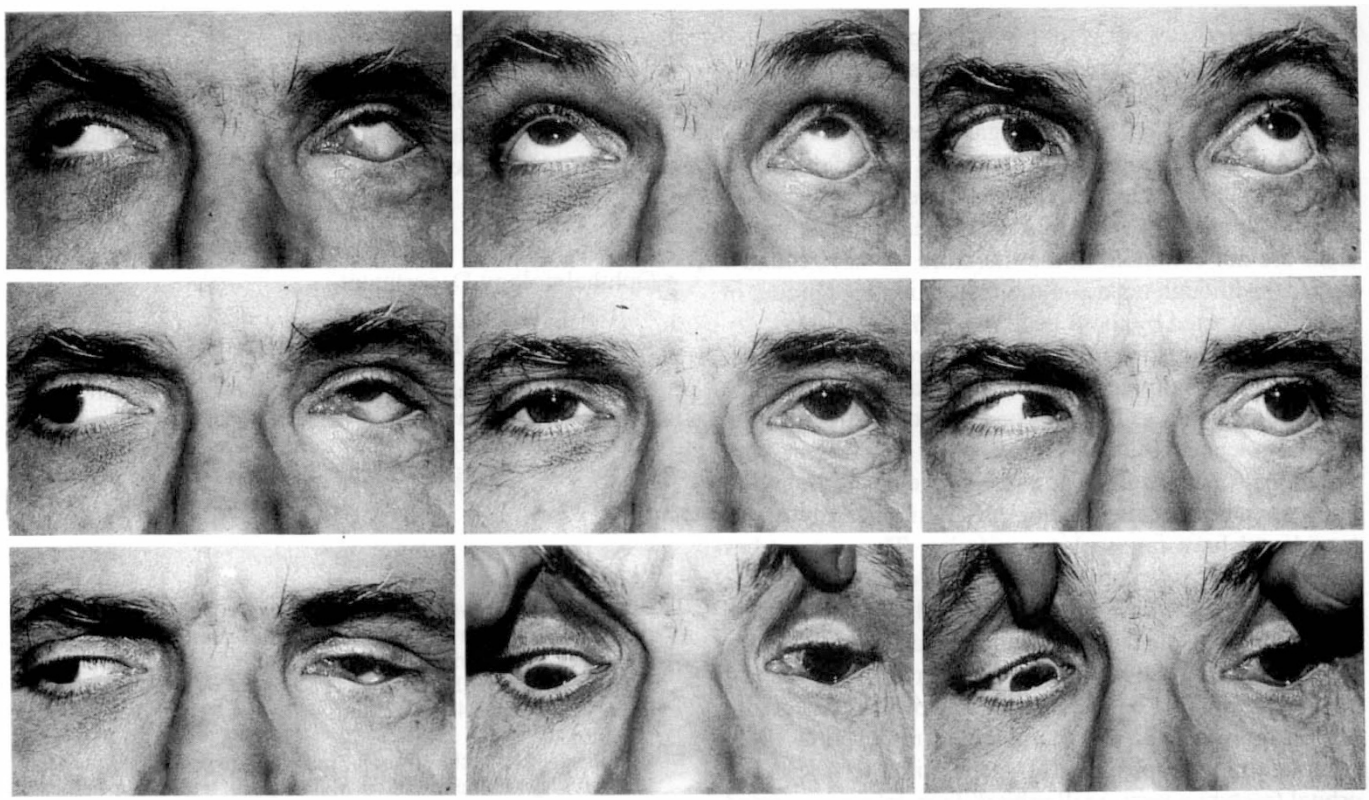

Fig. 1. *Photographs showing the patient's eyes in the nine positions of gaze. A fibrous mass is evident in the left infero-nasal conjunctiva.*

took to be a short period. On regaining consciousness he experienced a severe left-sided headache, slurred speech, diplopia, retraction of the left eye and infra-orbital anaesthesia. He was taken to the casualty department of the nearest hospital, and subsequently admitted with a suspected subarachnoid haemorrhage. Although the results of a CT scan and lumbar puncture were normal, a subarachnoid haemorrhage was still considered likely, and he was therefore transferred to the Department of Neurology, St. Bartholomew's Hospital, for a further opinion.

Neurological examination revealed that he had a mildly ataxic gait, and there was a mild left lower motor neuron facial nerve weakness. However, the diagnosis of subarachnoid haemorrhage was not substantiated. No cause was found for his collapse and at this stage the patient was referred for an ophthalmic opinion.

The patient's visual acuities were: right 6/4 N4.5; left 6/9 N5 with correction, not improved with a pinhole. The left eye was elevated and the patient experienced constant diplopia. There was fine manifest nystagmus which increased on dissociation and on lateral gaze. No oscillopsia was noticed. Ocular movements of the left eye showed marked restriction of abduction, moderate restriction of adduction associated with marked retraction, and moderate restriction of depression associated with retraction. The movements of the right eye were full (Fig. 1). The patient had mild left infraorbital anaesthesia. There was left enophthalmos and left ectropion. Forced duction and force generation tests proved the restrictive nature of the defect.

The patient was adamant that the condition had been recently acquired, except for the ectropion which he said was of 6 weeks' duration. In spite of direct questioning the patient denied that he had attended St. Bartholomew's Hospital before. Nevertheless it was obvious that the condition was not recently acquired. A biopsy of a fibrous mass in the left infero-nasal conjunctiva was planned, but the following day the patient disappeared from the ward.

Discussion of this case with colleagues at Moorfields Eye Hospital triggered the memory of an orthoptist, who produced a set of photographs of the same patient who had attended there some years before under another name. A further set of notes under this name was discovered at St. Bartholomew's Hospital with additional attendances recorded. Enquiries were made at various hospitals and revealed the patient's extensive travels to many hospitals, often visiting a hospital on more than one occasion. Doubtless there are other attendances that we have not been able to trace.

Over the past 23 years this patient has attended hospitals on at least 54 separate occasions. He has spent at least 100 nights in hospital; investigations (including on some occasions investigatory operations) have been carried out on almost all of these occasions. The ingenuity of this patient can be illustrated by the following account of his travels during 4 weeks of May–June 1986 when he attended eight different hospitals, in locations as far apart as Scotland and the south coast of England. He visited at least three London hospitals during this time and appeared to travel directly from one hospital to another to stay as an in-patient in each.

Discussion

Munchausen's syndrome was first described by Asher.[1]

The characteristics are as follows: 'The patient is admitted to hospital with apparent acute illness supported by a plausible and dramatic history. Usually his story is made up of falsehoods.' Often some organic lesion from the past is used to lend credibility to the story. Asher described three types: (1) the acute abdominal type, (2) the haemorrhagic type and (3) the neurological type. Ophthalmic versions are not common. In the literature we have found 6 cases.[2–4] Although not a common condition the amount of resources wasted by these patients is considerable.

The characteristics of this patient are that he usually presents to casualty departments complaining of diplopia following trauma to the eye, or symptoms suggesting a cerebrovascular accident. Occasionally he presents with symptoms of myocardial infarction. He often claims to know members of the medical profession. Many of his 'accidents' have taken place on trains. This patient has been seen by psychiatrists on several occasions but he does not appear to have followed up the treatment offered.

The original diagnosis remains obscure because this man is a liar and he has had many operations on his left eye. We know that he had a silastic implant inserted into his left orbit in 1982 and that this was removed in 1985. Although radiographs and CT scans failed to reveal any orbital fracture a very small orbital floor defect was noted at one exploratory operation. Evidence of left medial rectus muscle surgery was also noted and it has been suggested that this may be a case of Duane's retraction syndrome. Possibly this was the original diagnosis which has been complicated by an orbital floor fracture and fibrosis caused by repeated surgery.

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We would like to thank Mr. R. A. F. Whitelocke for permission to describe this case, and Bernadette McCarry whose good memory started us off on our search. We are also grateful to our colleagues throughout the United Kingdom, too numerous to name individually, who have given us information on this patient.

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