in a diverticulum. There was no previous history of diverticular disease. The patient subsequently made a good recovery.

Our patient was taking three drugs which can cause gastrointestinal symptoms. One of the side effects of neostigmine includes abdominal cramps. Intestinal perforation following azathioprine is a complication usually seen after transplantation and it is likely that it is due to concomitant steroid therapy.² Patients on steroid therapy are at increased risk of gastrointestinal perforation.¹ Approximately 20% of all perforations related to diverticulosis occur in patients who are on steroid therapy.³ Fadul *et al.*⁴ have shown that perforation is more common in patients being treated with steroids for neurological disease. In their study there was no correlation between risk of perforation and the dose or duration of steroid therapy.

In the presence of steroids, gastrointestinal perforation is difficult to diagnose because signs and symptoms of perforation are masked by the anti-inflammatory effect of the steroids. Our patient's symptoms were initially thought to be caused by neostigmine. The localized abdominal tenderness however, led to further investigation and diagnosis of perforation which occurred 5 days following the increased dose of prednisolone.

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Munchausen's syndrome diagnosed by radiological examination

Sir,

Munchausen's syndrome is an uncommon disorder in which patients attempt to seek repeated admission to hospital, often subjecting themselves to painful or physical distress in the process. Asher¹ divides the clinical types into abdominal, haemorrhagic and neurological. We describe a case of haemorrhagic/abdominal Munchausen's diagnosed by X-ray examination.

A 56 year old woman presented to the casualty department complaining of acute abdominal pain. She said that she had longstanding ulcerative colitis which had been quiescent until the previous 72 hours when she had been losing a large amount of blood per rectum. She said that she was only travelling through and that she was usually under the care of a consultant in a well known general hospital in the north of England. Further questioning about family, relatives,

acquaintances all proved fruitless. Neither the consultant she referred to nor case notes in her name existed at the hospital mentioned.

On examination she appeared to be restless and constantly crying in pain and asking for analgesia. She resisted general examination, but her abdomen, which was noted to be scarred from multiple previous operations, was soft and bowel sounds were normal. Before proceeding to rectal examination it was decided to perform pelvic and abdominal X-ray examination. This revealed multiple solid objects in the rectal area (Figures 1 and 2). During an examination under anaesthetic 5 double-edged razor blades were removed from the rectum. The patient discharged herself on recovering from the anaesthetic.

Suspicion that this was a case of Munchausen's disease was aroused early in the care of this patient because of certain features in the history – a person 'travelling through', with a lack of referral notes, or of relative contacts. There was also a

Figures 1 and 2 X-rays of rectal area.

history of previous treatment given a great distance away. Unlike malingerers, patients with Munchausen's may cause real illness from their actions such as using sharp foreign bodies to induce bleeding. Deferring the rectal examination until X-ray films were performed saved the junior staff possible injury. In conclusion, if the diagnosis of Munchausen's syndrome is suspected in a patient presenting with abdominal pain or blood loss, radiological examination should be performed to look for foreign bodies.

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