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A Serious Suicide Attempt Causing Brain Damage?

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Abstract

This is an interesting case of a serious suicidal attempt of a patient and his care pathway that followed his management by different teams, the use of the mental health act 1983 and the difficulties faced by health professionals in managing this case in London busiest hospitals. A 22-year-old Turkish man is discussed who attempted to hang himself on the 25th May in front of his girlfriend with a belt, using the bed bars following an argument with her and he was intoxicated with alcohol. This case raises important issues and highlights the difficulties of assessing and offering treatment to patients with personality disorders as they present with impulsive and dangerous behaviours which can lead to their own death.

Keywords: Suicidal attempt; Brain damage; Alcohol; Hyperthermia; Subarachnoid haemorrhage

He was also under the influence of alcohol (one bottle of wine 20% and a bottle of Turkish spirit 45%).

He was found by his father unconscious who performed CPR for 15 minutes. On arrival London ambulance service intubated him, his Glasgow coma scale was 4/15. (it's unclear if the patient had a cardiac arrest). He was Air lifted to Royal London hospital and then he was transferred to St Thomas hospital ITU as there were no ITU beds in Royal London.

Management

At St Thomas ITU he required ventilation. He was extubated on 28th May (intubated/sedated for 3 days in ITU). On his clinical investigations: Chest X-ray with extensive bilateral patchy shadowing 27th May, aspiration pneumonia treated for 5 days course of antibiotics. On the computed tomography head scan which was reported by the SPR: "showed frontal lobe ischaemia". There were no fractures, no cerebral oedema and no bleeding. However, there were no abnormalities reported by the Consultant Radiologist who reviewed the scan again on a later stage though.

He wanted to leave the hospital following regaining of consciousness on 28th May and he was put on Section 2 of the Mental Health Act on 29th May at St Thomas ITU. He was transferred to acute care Unit at Homerton Hospital on the 30th May.

In terms of his family history, his parents were alive and well and his Mother has hearing problems. His is the first of 3 children. He has a 9-year-old sister and an 8-year-old brother, he has a good relationship with his family. There were no Mental Health problems in family. About his personal history, he was born in UK. He had a good childhood and had elementary and high school in Hackney. He truanted in school and bullied others. He did GCSE with all C and 1 A. He went to college to study IT for 2 years and worked as a sales assistant in different companies with each job lasting 6 months-18 months. His current relationship was for the past 5 years and described as "good but very intense". In his past medical nil was reported where in his past psychiatric history a previous suicidal attempt 2 years prior following an argument (under similar circumstance) he took 35 tablets of iron.

He started drinking between the ages 15-16 and currently he is a binge drinker previously drinking half bottle of whisky and 1 bottle of wine on weekends. There were no symptoms of

Introduction

The World health Organisation reports that nearly 8 lakhs people die from suicide each year [1], which is one in every 40 seconds [1]. Some of these methods in Europe are poisoning by drugs 12.7%, poisoning by other means 5.1%, hanging 49.5%, drowning 4.2%, firearms 7.6%, jumping 9.5%, moving object 5%, and other methods 6.3% [2]. It's paramount to understand what lead people to this kind of behaviour which leads to their death. Providing an understanding of the precedents can help us prevent perhaps future suicidal attempts. Also the difficulties in working with these patients are demonstrated and their lack of engagement with the services provided. In this article, an interesting detailed case is discussed.

Case Report

A 22-year-old Turkish man attempted to hang himself on the 25th May in front of his girlfriend with a belt, using the bed bars following an argument with her. His girlfriend who witnessed the incident called his family immediately for help.

dependency. He smokes 5 Cigarette/day and he denied use of illicit drugs. In his social history he lives with parents. He works as a sale assistant in a tyre shop. In his forensic history he reported 16-19 fines for criminal damage, ABH, GBH, possession of offensive weapon but with no convictions so far. However, from the liaison Police officer: Aggravated harassment arrested (abusing his Somali neighbour), previous use of threatening language and a possession of an offensive weapon (knife).

He was managed on an acute mental health ward in Hackney, following transfer from the acute care unit to mental health ward on 1st June; he was placed on 15 minutes observation in the ward. On the ward round 3rd June, he was given 8 hours leave per day. He was referred to home treatment team on 7th June and he was taken off section.

He was also referred to the home treatment team for assessment, review and on-going management of this difficult case. He engaged with the HTT for the initial assessment on 7th June with no suicidal ideation reported, denied plans to harm himself. He was seen on the 7th and 8th June and understood that alcohol has been harmful "solely due to alcohol he harmed himself" he stated.

He was unlikely to access support from the mental health services, and he minimised the nature of the problems. He was seen by the HTT Clinical Psychologist on the 10th June and he reported that he is planning to get married, describes him as "perfect", and he wants his girl to be honest with him, as he has felt jealous and insecure. He subsequently stopped working with the Home Treatment Team and refused to be seen.

Discussion

The consideration of differential diagnosis was the following:

- F60.2 Dissocial personality disorder
- F60.8 Other specific personality disorders "narcissistic"
- F69 Unspecified disorder of adult personality and behaviour

It was very difficult to work with this patient as he did not acknowledge his difficulties and he imposes a high risk towards self and others. This comes as a very difficult task for psychiatrists and health professionals to manage patients with personality disorders and often the feelings of hopeless and helpless are the counter transference felt by the health professionals as well as the feelings of potentially facing a future coroner's court.

The patient may be at risk in the future from legal and illegal substance abuse. He could be an excellent candidate for possible referral to group based psychodynamic therapeutic community where by he can explore inter-relationships, self-destructive behaviours in the here and now and how this links to possible past abuse he may have suffered.

Near hanging and sequelae

Survival without neurological damage is possible after attempted suicide involving near hanging. Initial neurological assessment is a very poor guide to final outcome (including fixed, dilated pupils). The worst prognostic indicators are absent or agonal respiration, absent vital signs or the need for resuscitation [3].

The patterns of injury are quite different to those seen in judicial hanging [4]. Cervical spine injuries are quite rare. Injury mainly arises through pressure on the neck veins and arteries [5]. Compression of the airway is less common. The external compression causes venous cerebral congestion, hypoxic circulation and reduced arterial cerebral supply. Pulmonary complications include pulmonary edema (ARDS) and bronchopneumonia secondary to aspiration [5].

The edema may be from a centrally mediated massive sympathetic discharge that produces an intense generalised vasoconstriction and a fluid shift from the high resistance systemic circulation to the low resistance pulmonary circulation [6]. The other cause of pulmonary edema is secondary to negative intrathoracic pressures generated as the person attempts to inspire through an obstructed airway. Laryngeal injuries may occur [6]. Thyroid cartilage fractures are the most common with fractures of the hyoid bone and cricoid cartilage seen less often. Damage to these structures is more common in those over 40 years due to calcification and where a narrow ligature has been used [7].

Other neurological injuries include various spinal cord syndromes [8], focal cerebral deficits, transient hemiparesis and larger infarctions. Various nerve palsies also occur. Cerebral edema [9] is could be present if there has been a significant injury. Other described injuries include traction injuries to the carotid arteries where bleeding into the vessel wall or intima occurs. Hyperthermia, status epilepticus, subarachnoid haemorrhage, ruptured oesophagus and pneumoperitoneum have all been described. Facial petechiae and sub conjunctival haemorrhages are common [9].

Conclusion

This case raises important issues and highlights the difficulties of assessing and offering treatment to patients with personality disorders as they present with impulsive and dangerous behaviours which can lead to their own death.

Emphasises the pressure that health professionals are faced on a daily routine with patients that don't engage with treatment options offered as for example psychotherapy and regular psychiatric follow up and the high risk they impose to themselves in the community in the long term where some of these patients eventually manage to kill themselves.

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