

CASE REPORT

Sherlock Holmes Approach to Suicidal Attempts

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ABSTRACT

A middle aged differently abled male patient was brought to the emergency department with complains of multiple injuries after sustaining a fall from stairs at home around 6 hours ago. The patient had previous history of depression disorder due to Schizophrenia and similar traumatic events in the past.

KEYWORDS

• Schizophrenia • Craniotomy • Transient ischemic attack • Cerebrovascular accident

INTRODUCTION

Suicide is a major cause of death among patients with schizophrenia. Research indicates that at least 5–13% of schizophrenic patients die by suicide, and it is likely that the higher end of range is the most accurate estimate. Hopelessness, social isolation, hospitalization, deteriorating health after a high level of pre-morbid functioning, recent loss or rejection, limited external support, and family stress or instability are risk factors for suicide in patients with schizophrenia. Suicidal schizophrenics

usually fear further mental deterioration and they experience either excessive treatment dependence or loss of faith in treatment. The neuro-biological perspective offers a new approach for understanding self-destructive behaviour among patients with schizophrenia and may improve the accuracy of screening schizophrenics for suicide.

CASE REPORT

A 53 years old male patient who is deaf and dumb since birth was brought to ED with

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polytrauma. He has been suffering with depression disorder due to schizophrenia for the last ten years. Patient had hallucinations and delusions. Patient had forgetfulness and had altered behaviour in due course of his treatment. Patient has a history of undergoing craniotomy surgery done 4 years ago in view of intra-cranial bleed. He also had a history of transient ischemic attack around 15 years ago. Patient had allegedly sustained multiple injuries after having fallen at his own residence around 6 hours ago. On physical examination patient was conscious, coherent and cooperative. He was afebrile and the vitals were stable. He had sustained injury to right orbital area leading to racoon eye and two lacerations of 1x1cm over the right upper eyelid and 3x2cm over mucosal aspect of lower lip. He had right facial swelling with nasal bleeding. Other injuries included tenderness over the right shoulder with restricted mobility along with tenderness over the right elbow. He had swelling, tenderness and crepitus over the right knee. There was no history of loss of consciousness. The patient did not have any vomitings or seizures post trauma. There were no chest or abdominal injuries. Patient was on medications like Fluoxetine and Olanzapine for his depression disorder, Levipil and Telmisartan for post craniotomy and transient CVA. All necessary investigations and consultations were taken to treat the patient in EMD.



Figure 1: X-ray of right knee (lateral view) showing transverse patella fracture with normal presentation of femur, tibia and fibula bones

Laboratory blood investigations were with normal limits. Whereas, X-ray showed right closed transverse patella fracture along with a closed lateral condyle fracture of right humerus. There was a right zygomatic and maxillar fracture with fracture of the inferior wall of the right orbit. The CT scan of brain was normal. Neurosurgeon and plastic surgeon opinions were taken. They advised for conservative management for the above injuries. The ortho team advised for an above knee slab placement. The procedure was uneventful.



Figure 2: X-ray of elbow joint (AP view) showing lateral condyle of humerus fracture, with normal presentation of radius and ulna bones

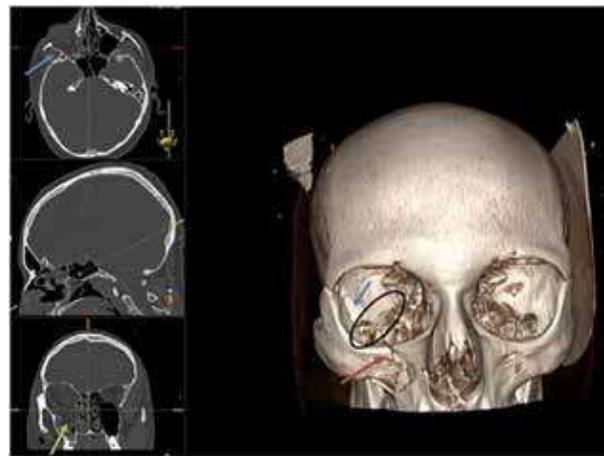


Figure 3: MRI brain with bone window & 3D Facial bones (AP view) showing zygomatic maxilla fracture with inferior Orbit fracture

DISCUSSION

Drug history indicated poorly treated schizophrenia. History may be misleading or suppressed by at tenders to avoid a medico-legal case. Suicide and suicidal attempts occur at a significantly greater rate in schizophrenics than in the general population. Clinical risk factors include attempted suicide, depression, male gender, substance abuse and hopelessness.¹ Apart from treating present illness, at tenders have to be counselled regarding re-occurrence of suicidal attempts in future. The psychiatry literature routinely quotes a lifetime schizophrenia suicide prevalence of 10% based on 1 meta analysis and 2 studies on chronic schizophrenics.² This proves the importance of taking a proper history after stabilising the patients as per ATLS guidelines.

Proper evaluation and treatment in the emergency department can avoid unnecessary admissions. Previous history of craniotomy may be for a similar trauma out of attempted suicide. The use of antipsychotics, antidepressants, anxiolytics and mood stabilizing drugs to reduce the risk of suicide in schizophrenia is reviewed. Typical antipsychotic drugs like haloperidol have not been reliably shown to reduce the risk of suicide.³ Up to half of the suicides among patients with schizophrenia occur during inpatient admission.⁴ In another matched controlled study of 30 chronic schizophrenic patients, eighty percent were male and committed suicide at a mean age of 25.8 years after a mean duration of illness of 4.8 years. Significantly more of the suicides had a chronic relapsing schizophrenic illness where 23.3 percent committed suicide while admitted and 50 per cent of the outpatients committed suicide within three months of discharge from in patient care.⁵

CONCLUSION

Proper history taking is of paramount importance in events of trauma. Detailed history of medications can help in our "SHERLOCK HOLMES" approach. Compliance is often an issue with chronic diseases, especially psychiatric. Relatives must ensure that the medications are dispensed by them, insist the medications are administered by them or in presence of them. Periodic review by the treating psychiatrist is often missed even in the educated classes. This review helps in customising medications from time to time.

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