SELF-AMPUTATION AND BURNING – SERIOUS SELF-MUTILATION IN PSYCHOTIC PATIENTS: CASES REPORT WITH LITERATURE REVIEW

Cotter, M.*; Carvalho,A**; Delgado, L. ***
*Psychiatry resident at Centro Hospitalar do Médio Tejo (C.H.M.T.), Portugal; **Psychiatrist at C.H.M.T, Portugal; *** Department director at C.H.M.T, Portugal

Introduction:

Self-mutilation (SM) has been defined as any deliberate destruction or alteration of body tissue in the absence of conscious suicidal intention. These can be minor injuries such as scratching the skin with nails, burning with cigarettes, moderate injuries such as superficial arm cuts, or very serious injuries such as self-enucleation and self-tapping. Other severe forms of self-mutilation found more rarely are self-amputation (eg, hands or fingers) and the introduction of objects into the body (needles). Severe self-mutilation are rare in psychiatric practice, the most serious forms of self-injury are usually done by psychotic patients, especially schizophrenia and substance abuse. Other predisposing factors of SM include childhood traumas, guilt and conflicts over sexual acts or conduct, transvestites, suicide attempts or other self-destructive behaviors, social withdrawal and being depressed.

Cases report: Report of two cases of mutilation in psychotic patients. Both cases assumed as schizizophrenia.

A., male, 42 years old, single, with no psychiatric history, referred from surgery to psychiatry after amputating 5 fingers (left hand) with an ax and alleged suicide attempt (1st floor jump). For three years now, social isolation, affective dullness, and elusive and suspicious behavior have been present. Throughout his life he only had two affective relationships. He was hospitalized for diagnostic and treatment clarification. During the same it was possible to verify the presence of hallucinations in the form of command voices and persecution delusional activity, nevertheless he never justified a reason for the self-mutilation behavior . In addition he presented depressive tone mood. After discharge from the hospital he was integrated into day hospital regime so that the psychopathology was monitored and the risk decreased. Therapeutic adjustments were made and his current psychopathology is stable with regret for what happened. He is currently medicated with olanzapine 5mg/day and Paliperidone depot 150mg monthly.

L., female, 21 years old. In 2014 the first psychiatry contact and diagnosis of mild depression, medicated with Fluoxetine and psychological accompaniment but with non-compliance of the medication. She presented social isolation, irritability, disorganization, lack of personal hygiene and marked functional disability. Progressive aggravation of the clinical condition with impulsivity, irritability, marked increase in appetite associated with a 20kg weight increase, desorganization and behavioral inadequacy (accumulation of feces in bags in her room), carelessness in personal hygiene, daytime hypersomnia, excessive spending and agitation. She was admitted to psychiatry service for a brief period and left with suspicion of severe mixed-state bipolar disorder/insidious onset psychosis, and started mood stabilizers. One year later she was taken to the emergency for psychomotor retardation, emotional lability, bizarre speech, perplexed looking, thought blocks, anxiety, insomnia, neologisms, soliloquies, unmotivated laughter, delusional and persecutory ideation, visual and complex auditory hallucinatory activity, bizarre attitudes like coprophagia, eating pubic hairs and trichotillomania and her hand self-burned with cigarette that she justified as "voices that tell me to burn myself otherwise I won't get back the love of my life" She was hospitalized with Paranoid Schizophrenia diagnosis and medicated with Paliperidone 9mg/day, Clozapine 100mg/day and Lorazepam 3mg/day. She has been presenting many hospitalizations for psychotic decompensation, in one of them she cut his hair in a psychotic context. In the medical consultation, successive adjustments of the medication have been made with a goal for symptom improvement but it still persists. She started monthly 400mg abilify maintena injection, valproic acid 300mg 2id, clozapine 100mg/day and biperiden R/day due to delirious state with persecutory ideas and auditory hallucinations

Extreme, bizarre and very severe forms of self-mutilation are associated mainly with psychotic conditions, especially schizophrenic patients in delusional / hallucinatory states. They are also described in toxic psychoses, alcohol intoxication, sexual identity disorders, affective disorders, and personality disorders. They are considered rare in the literature, although their prevalence is probably underestimated. Self-amputation (mainly hands and fingers) in schizophrenic patients is rarely reported in the literature.

Conclusions:

Intentional self-amputation of a limb is rare and most likely to occur under psychosis. Common features of patients who self-amputate include psychosis with command hallucinations, religious beliefs and delusions of external control or salvation. SM patients require immediate intervention, seeking collaboration between psychiatrists, surgeons and emergency medical professionals. Self-mutilation episodes are rare in schizophrenic patients. Nonetheless the prodrome symptoms or provoking situations should be identified in order to promptly institute strategies to prevent or lessen the risk of new episodes. There are several risk factors like: previous self-mutilation; religious beliefs; imperative voices; sudden alteration of auditory hallucinations; increased psychomotor activity; outward behavior with staff and other patients. In addition, on patients in whom prodromes of self-mutilation episodes can be identified, immediate measures should be instituted to prevent such acts (such as constant vigilance, chemical and mechanical containment).

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