ATTEMPTED SUICIDE BY BURNING

BY

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Attempted suicide by burning is rare. In suicide cases treatment of the physical injuries is complicated by the mental attitude of the patient, and physical and psychiatric measures must be combined from the beginning.

Case Report

On February 4, 1951, a married woman aged 30 was admitted to hospital suffering from severe burns. It was stated that the burns had been caused two and a half hours previously, when she had attempted suicide by setting her nightdress on fire. There were deep burns involving the full thickness of the skin over the front of the thighs and trunk amounting to about 15% of the total body surface. She was in great pain but was reasonably co-operative. The pulse rate was 112 and the blood pressure 110/80. Morphine, $\frac{1}{4}$ gr. (16 mg.), was given at once. Local treatment comprised the removal of blisters, simple cleansing of the exposed areas with cetrimide, and their covering with wide-meshed gauze and petroleum jelly, saline gauze, and cotton-wool. General treatment included the immediate intravenous infusion of one bottle (540 ml.) of glucose-saline, to be followed over the first 24 hours by the further infusion of four bottles of plasma. "Seclophen," 2 ml. (equivalent to 800,000 units of penicillin), was injected intramuscularly and further daily injections were planned.

A favourable fluid balance was confirmed after 48 hours, but the pulse rate remained between 110 and 120, and the evening temperature was rising. The haemoglobin was 88%. Cultures of organisms from the burned areas showed the presence of *Staphylococcus aureus*, sensitive to sulphonamides and streptomycin but resistant to penicillin. Streptomycin, 1 g. twice daily, was therefore substituted for the seclophen.

On February 12 all dressings were removed and the burned areas were allowed to dry by exposure to the open air of the ward. The temperature fell the next day to a subnormal level and remained down during the following week, and the discharge from the burned areas crusted up. Their appearance at this stage is shown in the photograph. During this period increasing apathy and depression gave rise to anxiety. At the first psychiatric examination, on February 13, the patient seemed bewildered and apprehensive. She stated that she had done some wicked thing for which she was being punished. She was refusing food or fluids by mouth. She was more agitated in the earlier part of the day, and was waking very early in the morning.

Her husband said that she had been increasingly depressed for the past three months, the depression having first appeared about two months after the birth of her second child. She had been waking very early and had been much more depressed in the early mornings. She had lost weight. Three months previously she had attempted suicide by coal-gas poisoning; on the day of admission she had again tried to gas herself, and when disturbed had set her nightdress on fire.

Her history and condition were typical of an acute puerperal depression of the type which responds to electric convulsion therapy (E.C.T.). This was advised as a matter of urgency, as her mental state was endangering her life. In view of the skin-grafting programme which was necessary it was decided to give E.C.T., when needed, to coincide with the patient's surgical procedures, and after

curarization with gallamine triethiodide to modify the convulsion. The programme worked out as follows.

February 19. First Operation Under General Anaesthesia. First E.C.T.—All sloughs were removed surgically. E.C.T. was then given. In the succeeding 36 hours one bottle of whole blood, one litre of normal saline, and two litres of glucose-saline were given. A Ryle's tube was passed into the stomach and a high-protein diet given by this means. Mentally the patient was still deeply depressed but no longer deluded or resistive.

February 21. Second Operation. First Grafting Procedure.—Under general anaesthesia, Thiersch grafts of

Photograph taken on February 19, showing appearance of burns at 14 days. Extensive full-thickness loss of skin which can be seen as a black necrotic crust dried by exposure to air for seven days.

intermediate thickness were removed from all available areas on both thighs and applied as postage-stamp grafts. The recipient areas were all granulating areas on the right side and all those below the umbilicus on the left side. One bottle of whole blood and one bottle of glucose-saline were given in the succeeding 24 hours. The patient's mental improvement had been maintained.

February 28. Third Operation. Second Grafting Procedure. Second E.C.T.—Under general anaesthesia the left arm was used as a donor area for further Thiersch grafts, which were applied to the remaining granulating areas. The second E.C.T. was given at the end of the operation.

Following this there was a dramatic improvement. Although still depressed in the mornings, the patient was fully co-operative, and in the afternoons became reasonably cheerful and spontaneous.

March 5. Fourth Operation. Third E.C.T.—All areas were re-dressed under general anaesthesia. The third E.C.T. was given.

The mental state had become almost normal. Although she was still somewhat lethargic, she was bright and cheerful, and was eating and sleeping well.

March 10. Fifth Operation.—All areas were re-dressed under general anaesthesia. Next day two bottles of whole blood were given. After the operation she showed a mild depression, which cleared up spontaneously in a few days.

March 14. Sixth Operation. Third Grafting Procedure.—The thighs were now available for further use as donor sites. Under general anaesthesia it was possible to obtain enough skin to cover all remaining granulating areas with grafts.

Two more bottles of blood were given on March 17. Thereafter the haemoglobin was always above 80%, and returned steadily to normal.

On March 27 all dressings were removed and the patient was allowed to move about freely. Small unhealed areas were soon covered by spread from adjacent epithelium. She was able to discuss her illness freely. An explana-

tion of its nature and treatment was readily accepted. She has remained perfectly well and free from any depressive symptoms for a year.

Comment.—This case demonstrates the lengths to which a deeply depressed patient may go in an attempt to commit suicide, as well as the necessity for early and complete co-operation between the surgeon and the psychiatrist in the handling of such a patient.

We would like to acknowledge the help received in the management of this patient from Mr. J. R. Thompson, who carried out all the initial surgical measures; from Dr. J. Laycock and his colleagues of the department of anaesthetics; and from Miss J. M. E. Quixley, the ward sister, who was responsible for the nursing care of the patient throughout her period of treatment.

Medical Memoranda

Neurinoma of Superior Cervical Sympathetic Ganglion

The following case is rare enough to warrant publication. It also provides an interesting lesson in differential diagnosis of swellings in the region of the angle of the jaw.

CASE HISTORY

A schoolgirl aged 12 had had a small lump in the right side of her neck since October, 1945. A diagnosis of tuberculous lymphadenitis was made at that time, and she was kept under observation at a clinic reserved for these cases. A carious tooth was removed; the chest x-ray film revealed no abnormality, the E.S.R. was normal, and Mantoux tests were negative at a dilution of 1:1,000. The patient, however, failed to attend for some time. Four years later, in October, 1949, she was seen again in the surgical out-patient department, having been referred by her own doctor because the lump had increased in size.

On examination a globular swelling 5 by 5 cm. was seen on the right side of the neck just below and behind the angle of the mandible. The tumour arose deep to the sternomastoid, had a smooth regular surface, and was of firm consistence. There was no tenderness or any fixation to the skin, and it could not be transilluminated. The tumour showed transmitted pulsation, and the carotid sheath had been displaced forwards and medially. No other glands were palpable in the neck. The pupils were equal, central, and circular. There was no other abnormality.

Operation.—On October 12, through a skin-crease incision over the tumour, the swelling was seen to be coming from deep to the carotid sheath, which was displaced forwards and medially. The tumour was easily enucleated by gentle blunt dissection, and its pedicle appeared to arise from the superior cervical sympathetic ganglion. The wound was closed without drainage. The pathological report on the tumour stated: "The specimen consists of an ovoid encapsulated tumour 5 cm. in greatest diameter. The outer surface is smooth and the cut surface is composed of an irregularly trabeculated white tissue containing dilated blood vessels. It is of rubbery consistence. *Microscopical appearances:* The tumour is a neurilemmoma composed mainly of a loose meshwork of cells of variable size and shape. In some areas there is definite regimentation of the nuclei, but this is not a prominent feature. Small intercellular vacuoles and large blood spaces are frequent. No nerve fibres could be demonstrated, and collagen fibres are scanty and irregular in distribution. There is no evidence of malignancy."

Horner's syndrome developed on the right side immediately following the operation. Six months after there was some improvement, but when seen again a year later, though there was considerable improvement, Horner's syndrome still persisted.

I wish to thank Mr. Arthur Hill for permission to publish this case, and Dr. A. B. Lintott for the pathological report on the tumour.

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A Difficult Wart Treated by Suggestion

It is well known that warts can be cured by suggestion, and there are many series of cases recorded in which the treatment was successful in a certain percentage of the warts. We venture to record a case in which suggestion was not only successful but in which it was the only possible treatment.

CASE REPORT

A brass-turner aged 39 had had for some years a large number of warts on his hands. Two years ago they had been curetted under local analgesia. This operation succeeded in the case of all the warts except two small ones and a very large one on the nail-fold of the ring finger of the right hand. This had recurred almost immediately, and it was soon evident that, in the process of curetting, the nailplate had been damaged in the neighbourhood of the lanula and the wart was now growing in the matrix (Fig. 1).

FIG. 1

FIG. 2

The finger was painful and interfered with his work. Indeed, he came to hospital prepared to submit if necessary to amputation of the phalanx.

It was clear that any surgical treatment successful in destroying the wart would leave the patient with a permanently split nail. We did not feel justified in exposing the nail matrix to what we believe to be the dose of x rays required for the destruction of a wart. We decided, therefore, that the only treatment that could possibly result in a *restitutio ad integrum* was to make the wart disappear by means of suggestion.

One of us (L. C.) undertook to remove the wart by suggestion. The patient, though friendly and co-operative and in his own words "willing to try anything," was openly sceptical.

The mechanism of suggestion was explained in detail with illustrative anecdotes. The history of the warts was taken in minute detail. During the interview the patient's attitude changed and he became receptive of the suggestion that he would be cured. He was instructed not to apply any remedy to the wart or even to cover it with a bandage.

Two weeks later the two small warts had disappeared and the large one was flatter. After a further two weeks the large wart had disappeared and there was some indication that the growing nail was smooth. At the end of six weeks the condition was as shown in Fig. 2. Seven months have now passed, and there is no evidence of the recurrence of this wart.

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