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Review

The surgeon and self-harm: At the cutting edge

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ABSTRACT

Surgeons frequently treat the consequences of self-harm. Self-harm is a common problem and presentations to Irish hospitals are increasing. It increases the risk of suicide and is associated with long term morbidity. Appropriate management can improve the prognosis. Surgeons require a number of skills to appropriately manage patients who self-harm. In this review we outline those skills including diagnosis, communication, capacity and risk assessment.

Introduction

Surgeons frequently treat the consequences of self-harm. The terms used to describe self-harming behaviours continue to change and evolve[1–3] and different terms are used between medical specialities and internationally.[4] For the purpose of this review self-harm refers to a self-directed behaviour which results in an injury.

More than 12,000 people presented to the Irish Emergency Departments as a result of self-harm in 2012, 20% of whom repeated the act within 3 months.[5] This figure represents a 20% increase in presentations since 2002. Only a percentage of patients who self-harm will seek medical attention and therefore the true extent of self-harm is not known. Self-harm is the highest predictive risk factor for suicide and also increases the risk of death from natural causes.[6] Appropriate management of self-harm has the potential to decrease the risk of recurrence and the risk of suicide.

Self-harming behaviours can occur in a broad range of patients and contexts, with patients presenting to all health care providers. Surgeons will be familiar with the common presentation of the young adult who has self-harmed whilst intoxicated in the context of interpersonal conflict, sustaining superficial injuries which may or may not require surgical intervention.

The reasons for self-harm are complex but could be interpreted as a communication of distress. As a clinical sign of emotional distress, self-harm is analogous to pyrexia, as an indicator of an underlying process that must be clarified and

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addressed. Surgeons play an integral role in the management of this vulnerable group of patients. This review for surgeons aims to outline important aspects of self-harm including the relevance, key details and skills in management.

Why is self-harm important to surgeons?

Surgeons from all specialities will be involved in the management of patients who have self-harmed. Table 1 gives examples of self-harm leading to injuries which are managed by each surgical speciality.

Surgeons will find it helpful to cultivate a particular skill set when managing patients who have self-harmed including clarity around diagnosis, communication, capacity, risk assessment and management. Through appropriate management surgeons play a key role in decreasing the risk of associated disability and mortality.

What do surgeons need to know about self-harm?

Risk of suicide

Self-harm increases the risk of suicide 40 fold compared to the general population and is the highest predictive risk factor for suicide.[5] Alcohol misuse is implicated in 40% of cases of self-harm and half of all cases of suicide have a history of alcohol abuse in the final year of their lives. Suicide is the commonest cause of death for 15–24 year old Irish men. Ten per cent of patients who self-harm will eventually die by suicide and is likely to be substantially higher in certain subgroups.[7,8]

Self-harm is recurrent

Patients repeatedly presenting to hospital due to self-harm represents a significant problem. The surgeon may find themselves treating the same patient with similar injuries on a number of occasions. In Ireland in 2012 over one fifth of all self-harm presentations were due to repeat acts, with the majority of patients repeating the self-harm within three months of presenting to the emergency department.[5] Patients who injure themselves by cutting are most likely to represent with further self-harm. In 2012, 3% of the all self-harm presentations were accounted for by 24 individual patients who presented on at least 10 occasions. Appropriate management has the potential to decrease the risk of recurrence.

Treatable distress

Self-harm always occurs in the context of distress and often in the context of substance misuse (usually alcohol). Treating the distress and alcohol problem is likely to reduce the risk of repeat self-harm or suicide.

For a subgroup of patients self-harm becomes a repeated (maladaptive) way of coping with distress rather than a suicidal act. Some such patients may be diagnosed with borderline personality disorder. Evidence based treatments such as dialectical behavioural therapy (a variant of cognitive behavioural therapy) have been shown to be effective in the treatment of these patients as per NICE guidelines.[9]

Other health care needs

Self-harm can result in lifelong disability. In addition to the direct consequences of self-harm, patients who self-harm are at increased risk of premature death from natural causes.[6] Those with a history of self-harm die on average 30 years earlier than expected, the mean age of death for men is 50 yrs and women 54 yrs. Deaths due to natural causes are 2–7.5 times more frequent than in the general population and are particularly due to circulatory and digestive system diseases. Many people who self-harm have a physical illness, which is often poorly managed. The self-harm presentation is an opportunity for a broader health care intervention.

Social needs

Self-harm occurs in all sections of the population but is more common among people who are poor, those who are single or divorced, living alone, are single parents or have a significant lack of social support.[10] Many patients who self-harm have a history of significant childhood trauma (emotional, physical or sexual abuse).

Health care costs

Self-harm is associated with greatly increased direct and indirect health care costs.[11] The direct costs relate to the recognition, assessment and intervention of the multiple presentations to health professionals throughout the health service including the 12,000 emergency department assessments in 2012.[5]

Indirect costs include the effects on work attendance and productivity, legal costs, cost of long-term disability and premature mortality. Prevention of suicide is an important public health issue. Suicide is the third most common cause of life years lost from work, after cardiovascular disease and cancer.[12]

How should surgeons manage self-harm?

Recognising

The treating surgeon should establish the patient's role in their injury. This is determined through a comprehensive history of the events leading to the injury. This may require getting information from a number of different sources i.e. patient, family, gardai, health professionals, or witnesses, taking into account the reliability of the information.

The majority of patients will give a reliable history. However a proportion will not be reliable. Suggestive pointers for inaccurate histories include:

- Inconsistencies in the history
- Injury not congruent with given explanation
- Significant psychiatric history (e.g. previous self-harm/psychosis/current depression)
- Substance abuse (e.g. alcohol/illicit drugs or prescribed medications)