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Review Article

Self-Enucleation and Severe Ocular Injury in the Psychiatric Setting

Kimberly Clinebell, M.D., Robin Valpey, M.D., Teresa Walker, M.D., Priya Gopalan, M.D., Pierre Azzam, M.D.

Background: *Although the first medically-reported case of auto-enucleation was described in the mid-19th century, ocular self-gouging has long been depicted in historical legend and mythology. Cases of enucleation have since been identified across various cultures. Though relatively uncommon, this major form of self-mutilation now afflicts approximately 500 individuals per year, and may present more commonly among certain clinical populations.* **Methods:** *We present 2 cases of self-enucleation in patients with psychotic illnesses and review existing literature on the history of enucleation, associated pathology, and management (both medically and psychiatrically) for this serious form of self-injury.* **Results:** *Literature review includes a brief historical perspective of auto-enucleation and its context in psychosomatic medicine, with cases to highlight key aspects in the prevention and management of ocular self-injury. Normal eye pathology is described briefly, with a focus on medical care after self-inflicted damage, as pertinent to consultation psychiatrists. Interventions for behavioral and pharmacologic management of agitation and impulsivity are reviewed, including consideration for electroconvulsive therapy, in this particular context.* **Conclusion:** *Although severe ocular self-injury is uncommon, psychiatrists should be familiar with approaches to prevent and manage auto-enucleation in individuals at risk thereof. Consultation psychiatrists must work closely with ophthalmologists to address affective, behavioral, and cognitive triggers and complications of ocular self-injury.*

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HISTORY OF ENUCLEATION IN PSYCHIATRY

The first case of self-enucleation in Western medical records was reported in 1846,[1] though enucleation had long before been depicted in European mythology. Norse god Odin removed one eye in exchange for supreme wisdom;[2] according to Greek legend, Oedipus gouged both eyes after discovering his own incest and patricide; and Saints Lucia, Triduana, and Medana all allegedly removed eyes in response to romantic advances.[3] Modern cases of ocular self-injury from predominantly Christian countries often implicate Biblical verses from Matthew 5:29 ("If your right eye causes you to stumble, gouge it out and throw it away") and Exodus 21:24 ("Eye for eye, tooth for tooth, hand for hand, foot for foot") as a precipitant to enucleation.[4,5] Nevertheless, ocular self-injury has been identified across cultures, around the globe, and in association with an array of psychopathology.[6]

Enucleation is classified by Favazza and Rosenthal[7] as a major type of self-mutilation;[8] initially

Received September 14, 2015; revised October 23, 2015; accepted October 26, 2015. From the Department of Psychiatry, Western Psychiatric Institute and Clinic, Pittsburgh, PA (KC, RV, TW, PG, PA). Send correspondence and reprint requests to Robin Valpey, M.D., Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811, O'Hara Street, Pittsburgh, PA 15213; e-mail: valpeyre@upmc.edu
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thought to be rare, estimates of severe ocular auto-injury show approximately 500 cases annually.[9] Penetrating ocular damage interferes significantly with activities of daily living and has been associated with decreased quality of life.[9] More broadly, vision loss has been linked to depression, anxiety, social withdrawal, and hallucinations.[10–12] Psychiatrists asked to evaluate patients in this context benefit from a greater appreciation for nuances of self-imposed ocular injury. In this narrative review, we use case examples seen by the psychiatry consultation service at our institution to highlight important clinical considerations for practitioners of psychosomatic medicine. This includes psychiatric etiologies of enucleation, management of associated agitation, and provision of psychiatric care for individuals with ocular damage.

PSYCHIATRIC DIAGNOSIS AND SELF-ENUCLEATION

Various psychiatric conditions have been associated with enucleation; these include schizophrenia, most prominently,[6,13] in addition to obsessive-compulsive disorder,[14] affective disorders (particularly psychotic depression),[15] posttraumatic stress disorder,[16] Munchausen syndrome,[17] and borderline personality disorder.[18] All of these diagnoses should be considered in the initial differential when encountering a patient who has engaged in ocular self-injury. Individuals who enucleate often share common features, several of which may be considered to be risk factors or motivating precipitants: active psychotic symptoms, a belief that self-mutilation was necessary to save themselves or prevent further harm, a lack of subsequent regret, citation of religious dogma (e.g., Matthew 5:29), delusions or hallucinations with religious or sexual themes, and substance use.[4,7,13,19–21] Substance-induced psychosis, most commonly the result of phencyclidine, lysergic acid diethylamide, cocaine, cannabis, or amphetamines, has also reportedly precipitated a range of ocular self-harm.[5,16,22,23] These considerations are central to psychiatric assessment after enucleation, which should include evaluation for psychiatric syndromes that triggered ocular damage; identification of active symptoms that may drive further self-injurious behavior; and recent patterns of substance use, both to ascertain whether intoxication drove self-mutilation and to identify risk of a withdrawal state during subsequent medical care.[13,15]

CASE PRESENTATION 1

Mr. A, a 52-year-old man with chronic schizophrenia and a history of severe self-injury underwent a streamlining of his psychotropic medications (most notably, clozapine), in preparation for electroconvulsive therapy (ECT). Shortly thereafter, despite close monitoring, Mr. A attempted to gouge both eyes with his right thumb, prompting emergent medical attention.

In the general hospital, computed tomography revealed bilateral globe ruptures and a displaced lens in the right eye, with further examination revealing a retinal tear and detachment of the left eye. Mr. A was evaluated by ophthalmology and underwent emergent surgical repair; subsequent treatment included use of atropine, prednisone, and moxifloxacin ophthalmic drops. The psychiatry consultation service was asked to evaluate Mr. A, given concern for continued risk of self-harm postoperatively. On assessment, Mr. A was agitated with disorganized behavior; he perseverated on being possessed by and hearing the voice of Satan, and made comments about removing Satan through his eye. He was unable to provide any further explanation for his attempted self-enucleation. In addition to his recent medication taper and subsequent worsening psychosis, Mr. A had the additional risk factors of prior self-injury (including drinking bleach while at a state hospital) in the setting of active psychosis and religious fixation to his delusional thinking.

Owing to significant agitation, and with continued reference to harming himself, Mr. A was placed in 4-point restraints with 2 care attendants in his presence at all times. Despite these precautions, he remained agitated and repeatedly attempted to ram his extremities into the bed rails. Parenteral olanzapine was used on an as-needed basis for agitation, with little benefit, prompting subsequent use of intravenous lorazepam. Mr. A's recently prescribed psychotropic medications (including scheduled doses of quetiapine, clozapine, and clonazepam) were reinitiated; their titration ultimately permitted discontinuation of restraints, with continued 1:1 observation. Given its associated risk for increased intraocular pressure, ECT was deemed to no longer be a feasible option for Mr. A.

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