SELF POISONING : TWO CAUTIONARY TALES

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SUMMARY: Two patients who were admitted to hospital as possible cases of self poisoning are described. In each case serious organic disease was responsible for the presenting symptoms.

The importance of careful assessment of the many patients with self poisoning is stressed.

Introduction

Emergency admissions of cases of self poisoning are now very common. Recently two patients were admitted with a diagnosis of self poisoning, but in whom there was serious medical disease. Their case histories may be of interest.

Case histories

Case 1

Mrs. G. aged 60, had lived locally for many years and was well known to her family doctor. She had a very long history of depressive illness, but in recent years had been much improved on a regime of tricyclic anti-depressants and tranquillisers.

On the evening of 7 May 1974 she was sent to casualty with a full letter from her family doctor, having been found drowsy and confused by her husband when the latter returned from work. The doctor's letter concluded "I can only assume she has taken too many of her pills".

She was admitted shortly after midnight when she was drowsy and confused. Two other facts were noted, she was a heavy cigarette smoker and had "many rhonchi and creps both bases" (*sic*). Gastric lavage was performed and she was sent to the ward for observation.

When seen on the morning of 8 May she remained confused and drowsy. She was overweight, bloated, had finger clubbing, and there were gross signs of bronchopneumonia with basal consolidation subsequently confirmed radiologically. Muco-purulent sputum was obtained.

Her husband was seen later that morning when further details were obtained. The patient had been in good spirits recently. On the morning of 7 May she appeared to have a "bad cold". When her husband returned home that evening she had been drowsy and slow and he noted that she was attempting to repeat her normal evening dose of drugs with no recollection of having taken the earlier dose. He did not think she had taken many tablets as he "kept an eye on them", and there was no apparent deficit.

The patient was treated with antibiotics, physiotherapy, 24 per cent oxygen, and made a rapid recovery. She had a polymorphonuclear leucocytosis of $13,600/\text{mm}^3$ and a transient hyponatraemia consistent with severe lung infection. Unfortunately, initial blood for gas analysis clotted and further specimens were not taken. She was discharged well having restarted psychotropic therapy.

Case 2

Mrs. R, aged 34, was the wife of a serviceman. She was referred for admission on 4 June 1974 with a note that she had been treated with "Stemetil" for weakness and dizziness following a bout of gastro-enteritis. The family doctor had visited her at home that afternoon, found her drowsy and incoherent and established that neighbours had given her "Migril" and "Coldrex" for a headache. He wrote "I do not know if she has taken other drugs but I would be grateful if she could be admitted for observation".

The admitting doctor noted hypertension (190/110) and an equivocal plantar response. A second doctor saw her on the ward in the evening and noted some neck stiffness, but no further action was taken.

When seen the following morning she was drowsy and dysphasic. There was no neck stiffness, but the blood pressure remained high. Retinoscopy was normal. Lumbar puncture was carried out on the indication of a low grade fever with disturbance of consciousness. Moderately blood stained cerebro-spinal fluid was obtained which was sterile with a normal glucose content. A diagnosis of subarachnoid haemorrhage was made.

She was given methyldopa to control her hypertension but over the next four days her level of consciousness fell and she developed a right hemiparesis. A diagnosis of possible left hemisphere haematoma was confirmed by angiography at the Wessex Neurological Centre. Left middle cerebral aneurysm and considerable vasospasm were also seen.

She was transferred back to Tidworth taking dexamethasone and over the next ten days considerable improvement occurred, her blood pressure became normal and hypotensive therapy was withdrawn.

A second angiogram showed her aneurysm to be smaller and vasospasm to be less. She has subsequently made an excellent recovery with no residual neurological abnormality, but remembers nothing of the few days before or after admission.

Discussion

Both these patients were referred by experienced family doctors with the suggestion that there may have been excessive drug consumption, and in each case this assessment appeared to be accepted at least in part on admission.

The first patient had chronic bronchitis and developed confluent bronchopneumonia probably secondary to upper respiratory infection. The impression gained was that her drowsiness and confusion were related to the respiratory failure rather than self poisoning. The situation certainly called for vigorous treatment of the chest condition.

The second patient was one of the 10 per cent of cases of subarachnoid haemorrhage with an insidious rather than abrupt onset, and such cases may be difficult to diagnose. What little neck stiffness she had was apparently intermittent, but the high blood pressure and equivocal plantar response noted called for further consideration. In this case the subsequent development of a cerebral haematoma produced obvious signs, but had this not occurred an important diagnosis could have been missed.

Conclusion

At a time when self poisoning is one of the commonest causes of emergency medical admission to hospital, it is all too easy to attribute disturbance of consciousness to drugs. One is reminded of the well known situation of the unconscious patient brought in smelling strongly of alcohol and the importance of not missing head injury in this situation. It is important to remember that the patient who "smells" of drugs may have serious organic disease whose recognition could be vital.

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