Self-induced colitis

JANE S. BYRNE  
M.B., Ch.B.

D. S. HARRY  

M. W. P. CARNEY*  
M.D., F.R.C.P.I., F.R.C.Psych., D.P.M.

F. I. LEE  
M.B., M.R.C.P.

Victoria Hospital, Blackpool

Summary
The case is reported of a young ex-nurse with severe inflammation in the distal colon, extending 15 cm proximally from the anus, due to the self-instillation of a noxious substance, namely, caustic soda. She escaped detection over a period of months. The result was extensive inflammatory change in the terminal 15 cm of the large bowel, with gross macroscopic, histological and radiological abnormalities.

Case report
Mrs A. B., aged 29 years. In May 1973 she complained of severe abdominal pain and the passage of blood and mucus rectally, following several months of lower abdominal discomfort and rectal bleeding. There was generalized tenderness. Ulcerative colitis or Crohn’s disease was suspected but rectal biopsy was unhelpful and her symptoms subsided. Two weeks later she again complained of abdominal pain and rectal bleeding. She was very tender over the lower abdomen and rectally. Barium enema was normal. At laparotomy, the whole colon and 1 in of the terminal ileum appeared red and oedematous; no bowel was removed. Post-operatively, she repeatedly demanded analgesics and, a week later, symptoms recurred, with pyrexia and a white cell count of 29,000. Crohn’s disease was suspected but, at her own insistence, she was discharged for out-patient assessment. The next day, she reappeared in the Casualty department complaining again of severe abdominal pain and diarrhoea. Her temperature was 39.8°C, pulse 120/min, with abdominal tenderness and guarding. Rectal examination was painful, with obvious bleeding. At sigmoidoscopy, purulent exudate, blood and ulceration were noted. She was given local and systemic steroids but failed to respond. Operation was deferred in view of doubt about the diagnosis. A feature of her illness was extreme variation in the severity of the symptoms, exacerbations sometimes coinciding with brief visits home. Over the next 6 weeks two further sigmoidoscopies revealed intense inflammation. The patient continued to complain of bouts of abdominal pain and rectal bleeding, demanding analgesic drugs. A barium enema showed severe inflammatory disease involving rectum and sigmoid colon (Fig. 1). Eventually, in view of the severe rectal and abdominal pain, bleeding, high fever, and marked deterioration in her clinical state, the lower sigmoid colon was resected and a colostomy made in the right iliac fossa. Histological examination failed to confirm ulcerative colitis or Crohn’s disease, but there was marked fibrous thickening of the sub-mucosa (Fig. 2) and acute inflammatory changes in the mucous membrane (Fig. 3). The possibility was suggested of repeated contact with an injurious substance. Post-operatively, she had bouts of fever, but was eventually discharged.

She returned yet again to Casualty, complaining of abdominal pain, and also that the colostomy was not working. The colostomy appeared red and inflamed, and she was readmitted. Subsequently, during the last of many searches, a length of plastic tubing, a bag of caustic soda, and a large syringe were found in her handbag.

It was difficult to piece together the previous history but, medically, this began at about the age of 12 when she had an appendicectomy; some 5 months later she was readmitted with hysterical anaesthesia and some self-inflicted scratches inside her cheek. She subsequently attended, having swallowed a safety-pin, and also with persistent infected lacerations and haematomas. At the age of 17 a bronchoscopy for recurrent haemoptysis was negative. Some 2 years before admission, her marriage to a doctor broke up, leaving her with the care of her only child. She had been in hospital with drug overdoses, and had been suspected of being habituated to barbiturates.

In November 1972, she attended with gluteal abscesses, claiming that these resulted from injections in a London hospital. Over the years previously, she had many abscesses, on the chest, arms, buttocks, thighs and legs, and the source of these had not

* Present address: Department of Psychiatry, Northwick Park Hospital.
**Fig. 1.** Barium enema showing narrowing of the lumen with mucosal irregularities and sub-mucosal barium in rectum and sigmoid colon.

**Fig. 2.** Section of the rectum (× 90) with loss of mucosal surface and excess sub-mucosal fibrosis.
always been very clear. Her parents reported thirty-one admissions to hospitals in the London area alone.

Her subsequent course has been one of improvement, although there was a brief psychiatric admission following further abdominal pain and headache. She remained histrionic and demanding, but did admit to the simulation of some of her previous illnesses.

Discussion

The main features of interest in this case are the extent of the self-induced chemical damage to the colon, and the psycho-pathology underlying such behaviour.

The sigmoidoscopic appearance suggested a diagnosis of severe, active ulcerative colitis. Radiologically, however, the disease was limited to the rectum and sigmoid colon, with thickening of the wall, narrowing of the lumen, and the appearance of sub-mucosal barium. Changes were more suggestive of Crohn’s than of ulcerative colitis, but such severe Crohn’s disease, limited to the distal colon, would be unusual. The changes, then, were not typical of either condition. Sigmoidoscopic biopsy showed only acute, non-specific inflammatory change and, in the resected specimen, there was considerable concentric sub-mucosal fibrosis and, again, intense, superficial inflammation, sufficient to suggest to the pathologist the possibility of instilled noxious substances.

A remarkable range of foreign bodies has been inserted into the anus as a form of auto-eroticism. Self-mutilation also occurs among the severely sub-normal, the suicidally depressed and disturbed schizophrenics. This patient does not fall into these categories, the case being one of so-called Münchausen’s syndrome (Asher, 1951) or chronic addiction to hospital with simulation of various medical and surgical disorders (Mayer-Gross, Slater and Roth, 1969). These patients persistently attempt to get themselves admitted and subjected to surgical and other procedures, with remarkable ingenuity and indifference to suffering. Unlike hysterics, they consciously contrive their symptoms and signs but, in contrast to malingerers, their motives for doing so seem to be hidden from them.

Usually passive, dependent, and often possessed of socially admired qualities, they compensate for loss of affection in childhood and at subsequent times by seeking medical attention. They are preoccupied with things medical, and females often take up nursing. Indeed, our patient married a doctor. The medical interest they experience undoubtedly reinforces their addiction to hospital. From the medical angle, the situation is further complicated by reluctance to call a patient a liar, particularly when she is a colleague, and unwillingness to accept a purely clinical diagnosis without exhaustive series of special investigations.

These patients rarely own up, even when confronted
with evidence of the self-inflicted nature of their lesions and, when suspected, usually reject offers of psychiatric assistance and discharge themselves. There is no easy way of helping them and there are normally insufficient grounds for compulsory admission to psychiatric hospitals. However, they can at least be protected from the results of their own behaviour by dissemination of information about them among doctors and hospitals.

References


Water intoxication associated with oxytocin infusion

Audrey J. Ahmad
M.B., B.S., M.R.C.P.

Elizabeth H. Clark
M.B., B.S.

Howard S. Jacobs*
B.A., M.D., M.R.C.P.

Central Middlesex Hospital, London

Summary
During a mid-trimester abortion with high dose oxytocin infusion and intravenous fluids, a patient developed an acute dilutational hyponatraemia and coma. The relationship of water intoxication and synthetic oxytocin infusion is discussed and the literature reviewed.

Although twenty-three cases of water intoxication complicating infusion of oxytocin, including two maternal deaths (Lilien, 1968; Gupta and Cohen, 1972), have been recorded in the Commonwealth and North American literature (Liggins, 1962; Pittman, 1963; Whalley and Pritchard, 1963; Potter, 1964; Self, 1966; Silva and Allan, 1966; King and Hall, 1966; Brennan, Madden and Massant, 1967; Leventhal and Reid, 1968; Burt, Oliver and Whitener, 1969; Josey, Pinto and Plant, 1969; Bileck and Dorr, 1970; Storch, 1971; Turcot, 1971; Goodlin, McLennon and Choyce, 1969; Pedlow, 1970), the association is still not widely recognized. Thus, no mention is made of it in several of the standard text books of obstetrics, despite the fact that infusion of oxytocin in high dosage was first recommended for the treatment of missed abortions 15 years ago (Loudon, 1959) and water intoxication was first attributed to this form of treatment in 1962 (Liggins, 1962). The case of severe water intoxication associated with an infusion of oxytocin reported here may serve as a reminder of the potential hazards of a widely used procedure, and of the precautions which must be observed.

Case report
A 24-year-old woman was admitted to a district hospital for a therapeutic abortion because of an attack of rubella in the tenth week of pregnancy. She was a healthy-looking, well nourished primigravida, 17 weeks pregnant, with no abnormality on physical examination, and with no relevant past or family history.

At midday on the day of admission an intra-uterine injection of 20% saline was given, and an intravenous infusion of oxytocin in 5% dextrose in water started. In the first 10 hr she received 10 u of oxytocin in 1 litre of fluid and, as she did not abort, the rate of administration was progressively increased (Table 1). While the fourth and fifth litres were being infused, she was seen to be restless, drowsy and confused, and she vomited twice. About 38 hr after the infusion was started, she was found on the floor beside the bed, restless, comatose, and responding only to pain. The pupils were equal, widely dilated, and reacted sluggishly to light; the tendon reflexes were uniformly brisk and the plantars were flexor. There was no papilloedema. The pulse and blood pressure were normal. Seven hours later at 9.00 a.m. her condition remained unchanged. Blood was sent for urea and plasma electrolyte estimation. A plain X-ray of the skull did not show any fracture. Frusemide (80 mg) was given intravenously and intravenous dexta-
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Jane S. Byrne, M. W. P. Carney, D. S. Harry and F. I. Lee

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