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Case Report

Case Report of Self-Injurious Behaviour in an Intellectually Disable Female with Comorbid Seizure Disorder and Psychotic Behavior

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Abstract

Self-injurious behavior (SIB) is a broad term, describing behaviour that causes harm to one-self. SIB are more prevalent among individual with intellectual disability. This individual are greater risk for developing both physical and mental health conditions including seizure, anxiety, mood disorder and psychosis etc. Management of people with self-inflicted injury, having Intellectual disability (ID) along with seizure disorder and psychosis is challenging. The purpose of this case report is to review clinical findings in a patient who presented with severe pain abdomen, vomiting, fever, difficulty in micturition and burning micturition. A case report of an 14year old girl of ID (IQ=53%) with seizure disorder and psychosis having self-insertion of bizarre objects through normal bodily orifices is presented. The physical examination findings- febrile, pallor positive and tenderness in left illac fossa. MSE findings- she was uncooperative to examination and exhibited oppositional behavior, disinhibited behaviour.she also display inappropriate smile towards nearby peoples and shows aggression, hostility towards her mother. No hallucinatory behaviour was observed. Radiological findings reveals-radiograph of pelvis AP view shows- linear opacity of metallic density, lying obliquely in lateral aspect of sacrum. USG whole abdomen reveals, foreign body in left illac regions with surrounding inflammation, sigmoid colon oedematous, along with enlarged lymph nodes. Diagnosis of SIB and MR with behavioural abnormalities and seizure disorder was made (ICD-10, F70.1 + G40). OT procedure is carried out to remove foreign body from body.

Keywords: SIB, intellectual disability, seizure, psychotic behaviour, bizarre objects, bodily orifices.

INTRODUCTION

Accepted definition of self-injurious behaviour states that the individual's behaviour results in physical inury, evident by the presence or likelihood of tissue damage if not stopped, to one's own body [1]. SIB are more prevalent among individuals with ID and low level of adaptive behaviour functioning. SIB is the most distressing and intractable problem in the field of ID. Common co-morbid conditions are autism and genetic syndromes, along with seizure disorders. SIB has multifacet, it varies in its form, frequency, pattern of occurrence and co-occur with other behavioural problems. SIB has also been associated with seizure activity in the frontal and temporal lobes [2, 3]. SIB should be differentiated from self-mutilation, injury during or following seizure episodes. Depending on site, severity and mode of injury, SIB appears to have significance clinico-psychopathology. Individuals with ID, low frustration tolerance, aggression, impulsivity, underlying psychotic process are the possible explanation for SIB. Most common SIB are head banging, head hitting, self-bitting and self-cutting. In our case, the challenging behaviour of inserting bizarre objects through normal bodily orifices which poses injury and infection to the patient, interfering the functioning. There was a significant diagnostic and management challenge as SlB was due to ID, Seizure disorder or ongoing psychotic process.

Case Report

14 year old female, was brought to emergency department by her parents with complaints of severe pain abdomen, vomiting, fever and difficulty micturition on and off from last 3months and increasing since 3days. Patient got admitted in surgery female ward. Patient had episodes of seizure in surgery ward and psychiatry call was attended, and patient is found to have active seizure, jerky movement of arms with tonic contraction, flexion and vocalization lasting few

seconds with urinary incontinence and she had brief staring spells.

On enquiry, party gave history that she was diagnosed as a case of seizure disorder in 2016 from psychiatry OPD, and was on medication sodium valproate 600mg nad maintaining well, seizure free for past 3yrs.

She was born following a normal pregnancy and delivery at home. She developed convulsive seizure at 5years of age lasting 3-5mins, some associated with fever. Clusters of attacks occurred every 3-4weeks. She developed brief staring spells occurred 1-3times/month. She developed jerky movements of arms and tonic seizures with flexion and vocalization for few secs occurred every few months. She had developmental delay, and regression was not apparent with seizure onset. She walked at 2 and half years of age, monosyllable at 3yrs of age and remained self-absorbed. She was admitted school at 5yrs of age, but due to seizure episodes at school, she was dropped out from school. She was brought to psychiatry opd for 1st time in 2016, EEG was advised and reports shows generalized epileptiform discharge. She was treated with sodium valproate 600mg.

She walked independently, follows simple commands, feds herself, assisted self-care, minimal words with monosyllable mostly. She had no dysmorphic or neurocutaneous stigmata.

From 12years of age, she developed behavioural abnormalities in the form of talking, smiling, laughing to self, disorganized, disinhibited behaviour, aggressive behavior at times. She used to insert bizzare objects in her body orifices (nose, ears, vagina, anus). Once she inserted button in the ear and have to consult ENT specialist for this. And many occasion she was found trying to insert bizzare objects to her bodily orifices, family members stopped from doing so. In mean time she attained her menarchy, very poor self care, and required assistance to maintain hygiene during menstruation period, her menses are irregular. Abnormal behavior persistent mildly for past 1year and aggravated for 6months. She used to spend most of times in squatting position,used to fingers her private parts,takes excess time while urinating or passing stool. She had complained her mother of pain abdomen, burning micturition and difficulty in micturition, fever. With medicines from local physician she got symptomatic relief for a while. But her symptoms persisting on and off from last 3months.

On physical examination, febrile, pallor present, tenderness in the left illac fossa present.

On MSE, she was uncooperative to examination and exhibited oppositional behavior such as resisting, turning face to other side, not responding to commands, she also display inappropriate smile towards nearby peoples and shows aggression, hostility towards her mother. No hallucinatory behaviour was observed. A provisional diagnosis of SIB with MR with behavioural abnormalities and seizure disorder was made (ICD-10, F70.1 + G40). She was prescribed sodium valproate 800mg, olanzapine 7.5mg.Her IQ assessment was done, was diagnosed as mild MR(IQ-53%).

Her blood investigations LFT, KFT, blood glucose, electrolytes and haematologic indices were found to be within normal ranges.

Her USG whole abdomen reveals, foreign body in left illac regions with surrounding inflammation, sigmoid colon oedematous, along with enlarged lymph nodes.

Her radiograph of pelvis AP view shows- linear opacity of metallic density, lying obliquely in lateral aspect of sacrum.

Her CECT abdomen reveals- a metallic linear foreign body, upper part of foreign body located inside sigmoid colon for length of 6cm with tip at the level of midpart of right external illac artery and lower part in urinary bladder.

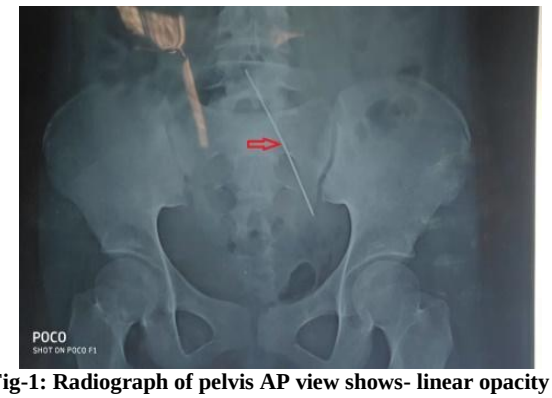

Fig-1: Radiograph of pelvis AP view shows- linear opacity of metallic density, lying obliquely in lateral aspect of sacrum

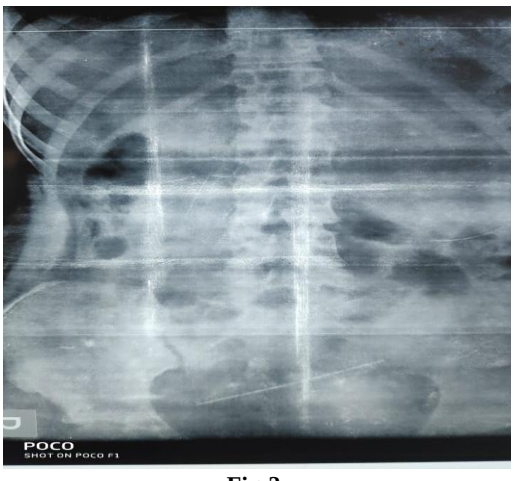

Fig-2:

On follow-up a week later, her parents reports she had no single episodes of seizure and aggressive behaviour calm down. Her psychotic behaviours have subsided, her appeptite has improved and sleep is adequate. But her abdominal pain and difficulty in micturition and burning micturition still persisting. She has been planned for operation for removal of foreign body.

DISCUSSION

First empirical studies of self-injurious behavior (SIB) in people with ID and ASD were conducted by Iver Lovass and colleagues [4, 5]. Most prevalent chronic health conditions in ID child are Epilepsy, cerebral palsy, anxiety disorder, oppositional defiant disorder, down syndrome and autistic disorder. In this case, patient has seizure disorder, ID with language deficit. Gordon [6] has recently reviewed the effect of epilepsy on language function. He concluded that there seems to be no doubt that language development can be adversely affected by the presence of epileptic activity as demonstrated by spike-wake discharges in the EEG. SIB has drawn attention from clinicians because of its life-threatening nature. A multidisciplinary approach is often required in such cases. Along with seizure episodes management behavioural problems also have to be managed. Psychotropic medication in treating behavioural and psychiatric disorder have been recently examined by the psychobiology commission of the International League Against Epilepsy [7].

Insertion of bizarre objects through bodily orifices is a dangerous behaviour as it carries risk of injury, bleeding, choking, infection. In the present case, the patient had vaginal injury, infection of sigmoid colon, fever, severe abdominal pain. Radiological imaging showing foreign body in abdomen with infection all around the abdominal viscera and have to undergo operation to remove the foreign body.

CONCLUSION

SIB is a serious medical condition. Its management is more challenging when it co-occurs with seizure disorder and underlying psychosis. It's a great source of stress to families. If not treated or undertreated, it may worsen and persist life long and at times life-threatening. Assessing the individual, its level of severity, accordingly management approach should be made. Antiepileptic treatment great value for controlling seizure. Antipsychotics drugs will be necessary for behavioural disorders. Family members should also be included and they should be made aware of the problematic behaviour,treatment consequences and how to deal with such individuals. Teaching the individual more adaptive skills, appropriate communication response. Applied behavioural analysis approach for problem behaviour, highly effective in ID patients.

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