Deliberate self harm

Editor,—Ryan et al present a valid case for the use of overnight admission wards in the management of deliberate self harm (DSH). From the data presented, the use of such wards reduces the need for psychiatric assessment of these patients.

My own experience of providing a DSH service which offers assessment to all patients who harm themselves would indicate that the provision of an observation ward improves the quality of psychiatric assessment and intervention. The contrast between working in casualty departments which do and do not admit DSH patients to an observation ward is often striking. Emergency assessments of DSH patients who are not deemed to warrant admission to a medical bed are frequently requested. In the absence of overnight observation beds, this often means attempting to address complex “multiple psychiatric and social problems” during the small hours of the morning, while the patient is still in crisis.

When DSH patients are admitted overnight, then a more meaningful assessment can be made, and full access made to the social and psychiatric support services. Patients will have had time to reflect upon recent events once they pass through a period of crisis. It is then possible to target appropriate interventions at those who will benefit most and patients can leave hospital with the appropriate follow up arrangements already in place.

There are in excess of 100 000 annual DSH admissions in the United Kingdom, and it is believed that 15-20% of these patients are not admitted within the following year. The provision of appropriate psychosocial intervention has the potential to both reduce the demands put upon A&E departments through readmission and to improve the quality of patient care offered. I believe that observation wards facilitate this process and would urge A&E departments to consider their use in cases of DSH.

The authors reply:

Thank you for offering us the opportunity to reply to Dr Gilbody's comments on our paper. We are encouraged that an association of psychiatry supports the use of an A&E observation ward in the management of deliberate self harm patients. Continued research in this area is important and we now keep a database of all patients who attend following an episode of DSH and are managed by the multidisciplinary team. Analysing these data base has stimulated us to look at other areas such as use of medication, that patients with a history of DSH with drug dependency, and the management of frequent offenders, all of which can be appropriately managed by an experienced multidisciplinary team based in an A&E department.

We concur with Dr Gilbody's statement that an observation ward can improve the quality of patient care; however, further research is required in this association of DSH with drug dependency for the long term impact of such a practice. Those of us working in A&E medicine are in a unique position to be able to study this further and should not neglect our academic responsibilities.

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Dogs, epilepsy and airways. The dog always wins!

Editor,—Injuries caused by dog bites are common and as many as 3 per 1000 population may attend accident and emergency (A&E) departments in any one year. The dog is also a common cause of attendance, with a prevalence in the population of 3%. However, it is rare that both problems will occur in the same patient at the same time.

Pet ownership is common among people with unstable epilepsy who had owned a large, but friendly, German Shepherd for a number of years. Unfortunately on the first occasion that the dog witnessed his master having a severe seizure the frightened dog attacked the patient's throat, causing a fracture of the thyroid and cricoid cartilages and puncturing the trachea. He presented to accident and emergency as a postural airway obstruction requiring an emergency tracheostomy.

The dog always wins!
The authors reply

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