

Letters to the Editor

Suicide Attempt by Anaphylaxis

TO THE EDITOR: The literature contains only 3 descriptions of attempted or completed suicide by anaphylaxis. Here we present the case of a young woman who attempted suicide by the deliberate ingestion of peanut butter.

Case Report

Ms. A, a 24-year-old female graduate student was brought by ambulance to our emergency department in anaphylactic shock. Ms. A reported that she had intentionally ingested peanut butter, a known allergen. A short time after the ingestion, she self-administered injectable epinephrine and text messaged her sister, who then called emergency medical services.

Paramedics found Ms. A lying on the floor of her residence. She presented as somnolent, diaphoretic, flushed, and covered in urticaria. Vital signs revealed tachypnea, tachycardia, and hypotension. She required resuscitation both in the field and in our emergency department with additional epinephrine, intravenous fluids, and corticosteroids. After stabilization, she was admitted to the intensive care unit.

Ms. A reported to the intensivists that she regretting contacting her sister and wished she had died instead. Psychiatry was consulted for safety evaluation. Ms. A had a history of serious suicide attempts, including a suicide attempt less than 36 hours before admission for which

she did not seek medical treatment. On examination, Ms. A was tearful and guarded. She reported becoming acutely overwhelmed because she was scheduled to defend her master's thesis. She initially reported that the ingestion was impulsive, but later admitted to several hours of planning before settling on anaphylaxis. She believed that an allergic reaction would be “the least painful way to die.”

The following day she was admitted to our inpatient adult psychiatry unit as an involuntary patient. All peanut butter was removed from the unit. Her stay was brief and she was discharged after coordination of outpatient services. These included intensive outpatient psychotherapy, coordination with her outpatient psychiatrist, and arrangements to delay her academic responsibilities.

Discussion

There are only 3 reports of attempted or completed suicide by anaphylaxis in the literature. The first is hypothetical: a young man reported to his psychiatrist that he had considered suicide by attempting to persuade a physician to prescribe penicillin, a known allergen.¹ In the second, a young man on an inpatient psychiatry unit with a peanut allergy ingested peanut butter and survived.² In another, a man's body was found near a lake next to opened tins of fish; he had a known fish protein allergy.³ Autopsy revealed anaphylaxis as the likely cause of death. The present case is the first reported involving a woman.

Although such few cases in the literature suggest that attempted and completed suicide by provoking anaphylaxis is extraordinarily rare, we worry that this may be an under-recognized method of self-harm. It is possible that cases of attempted suicide may be reported to be accidental by the patient in an effort to avoid psychiatric hospitalization and stigma. However, cases of completed suicide may be mistakenly ruled as accidental. Indeed, unlike other countries, the United States does not have a registry to monitor anaphylaxis-related deaths.⁴

We recommend that clinicians take care to assess whether their patients with both severe allergies and suicidality contemplate provoking anaphylaxis as a means of self-harm. It may also be prudent to be certain that patients at risk for suicide who have severe allergies have access to self-administered epinephrine.

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***Developing and Implementing
a Psychosomatic Medicine
Elective During Psychiatry
Residency Training: The
Embedded Psychiatry
Resident on a Bone Marrow
Transplant Unit***

To the Editor: Beyond the guidelines for core training in Consultation-Liaison (C-L) psychiatry outlined by the Accreditation Council for Graduate Medical Education and the Academy of Psychosomatic Medicine, there is little direction on how to establish and evaluate electives for senior residents interested in additional exposure to Psychosomatic Medicine (PM).^{1–3} We present here a psychiatric liaison program on the bone marrow transplant unit, developed as part of a novel 6-month PM elective for a fourth-year psychiatry resident. Accreditation Council for Graduate Medical Education core competencies (i.e. patient care, medical knowledge, practice-based learning and improvement, interpersonal

and communication skills, professionalism, and systems-based practice) were employed as the evaluating criteria for successful participation in the elective.

For the 6-month period from August 2014–February of 2015, under the supervision of PM faculty, the resident functioned as the sole psychiatry liaison to this 25-bed closed inpatient bone marrow transplant service that had never previously had an embedded psychiatric provider. The resident attended daily morning rounds and weekly team conferences. For patients identified by the team or the resident liaison to be in need of psychiatric intervention, the resident provided consultations, ongoing pharmacotherapy and psychotherapy, and family therapy when indicated. Additional liaison activities included staff and physician education on psychiatric issues relevant to this vulnerable and unique patient population. In addition, the psychiatry resident formed a “process group” for the physician assistants working on the bone marrow transplant unit. These groups met twice a month for a 45-minute period with the goal of effectively navigating work-related tensions through the fostering of team solidarity and collaborative efforts; self-reflection and interpersonal communication were encouraged.

The average number of consultations during this 6-month period was double than that of the same 6-month period the year prior. Typically, consultations requested were less likely to have a documented prior psychiatric history in the medical record, suggesting that as a result of having an embedded psychiatrist a broader subset of patients received the benefit of a psychiatric intervention. The presence of the embedded psychiatry resident resulted in 5 times as many patients

being started on a new psychiatric medication during their admission as compared to the year before. Accreditation Council for Graduate Medical Education core competencies were used as a formal evaluation measure at the midpoint and end of the elective. The Accreditation Council for Graduate Medical Education Milestones program that has since replaced the core competencies for assessing postgraduate medical trainees' performance and progress—including milestones specifically adapted for PM subspecialty training—could be readily utilized for this same purpose, facilitating an effective way to evaluate and provide feedback to the trainee, and assess the educational quality of the elective.⁴

Psychiatry residents considering careers in PM should be encouraged to pursue advanced electives beyond the required C-L psychiatry rotation. Our experience demonstrates that a new liaison role can be created for a senior resident, and effectively implemented and assessed using standard educational measures used by residency training programs.

Utilization of an embedded psychiatrist in medical settings has previously been shown to enhance patient care, and to result in a decreased length of hospital stay and favorable cost analysis for the hospital.⁵ Although the benefit of the embedded psychiatrist on a medical or surgical service is not a novel idea and with aforementioned established advantages, there is also a role for the embedded psychiatry resident on a medical/service unit as an opportunity for a specialized C-L psychiatry elective.

With supervision and thoughtful implementation, a liaison-based PM elective can offer a senior resident a formative training experience that