Outpatient presurgical evaluation of a patient with intentional self-mutilation from xenomelia: The value of preoperative consultation

Andrew Coulter, MD, MA; Elias Khawam, MD, DFAPA

Department of Psychiatry and Psychology, Cleveland Clinic

Introduction

In consultation-liaison psychiatry, patients are often seen in the inpatient setting, where the primary team has requested assistance with an issue that has arisen. There is considerable interest in the use of anticipatory means of psychiatric intervention to intervene prior to the development of complications. Outpatient presurgical consultation is utilized in several surgical specialities, such as bariatric and epilepsy surgery, as a means of assessing capacity, ability to adhere to recommendations, and prepare the team for any psychiatric complications.

Xenomelia is a disorder characterized by the patient's desire to remove healthy tissue or to become disabled in the absence of psychosis. It is rare, and not formally recognized in the DSM-5. Patients will often seek surgical removal of limbs, and when denied surgery, may self-mutilate to prompt amputation.

Case

45 year old male with a history of impulse control disorder, borderline personality disorder, and xenomelia who presented to the orthopedic surgery department requesting revision of bilateral leg amputations due to infection. He had a longstanding history of wishing he did not have legs and a significant history of trauma, and one year prior, had damaged his legs to the point of needing amputation. It was noted that he had injured healing surgical sites to prompt further amputation when he felt the limb stumps were not short enough. Psychiatry was consulted for presurgical evaluation.

Our evaluation clarified the potential risks (Fig.1) with proceeding with surgery, primarily, that the patient was still concerned about the aesthetic appearance of any amputation revision. Following previous surgeries, he admitted to reinjuring his legs, as he desired symmetry. Chart review from multiple local hospitals indicated hostility towards treatment teams and verbal aggression towards caregivers. In addition, he had a history of frequently requesting narcotic pain medications to manage his pain. We requested collateral, allowing us to confirm his psychotherapy participation and to gain better insight into effective treatment approaches. He recently had terminated care with his previous psychiatrist, so we advised him to establish care with another, and coordinated care with them.

Fig. 1 – Anticipated Risks

Anticipated Risks	Behavioral Contract
Poor adherence with outpatient psychiatric care	Establish care and obtain approval from outpatient psychiatrist
Limited coping skills or behavioral modification	Establish care and allow for collateral with outpatient therapist
Self-injurious behavior	Sitter to be placed through admission
Agitation and hostility towards treatment teams	Respectful communication and conduct will all members of healthcare team
Fractionated care, splitting	Open communication between all healthcare team members, whether at CCF or outside
Medication seeking behavior, concerns for factitious behavior	Reasonable and customary provision of pain medication

We assembled a multidisciplinary team to discuss our impression and to develop a risk mitigation strategy prior to scheduling surgery, which included bioethics and legal. Bioethics assisted with a behavior contract (Fig. 2), which the patient completed prior to surgery. The team held discussions with nursing staff on the orthopedics nursing unit to discuss boundaries and how to approach this patient, and to ensure sitter availability for the duration of the admission. He was admitted for surgical revision, completing an uneventful hospital course. He was readmitted once for a surgical site infection, which was determined to not be due to self-injury or manipulation. He remains with some chronic pain concerns, but has not required additional surgeries, and remained in his home state for care.

Fig. 2 – Behavioral Contracting

Discussion

In patients with serious mental illness, a preoperative CL evaluation can identify risk factors, ensure appropriate treatment and follow up, and allow for education of nursing and medical staff prior to the development of maladaptive behaviors or complications. Especially in patients with the potential to harm themselves or others, or with treatment-interfering behaviors, the ability to proactively intervene allows for a more effective and safer hospital admission.

We recommend advocating to surgical services to consider preoperative consultation in patients with complex psychiatric histories or medication regimens, or with concern for disruptive behaviors on admission. Currently, we have assisted numerous surgical services with preoperative discussions, including cardiothoracic surgery (valve repairs in patients with endocarditis from IVDA) and ENT (surgical resections in patients with severe alcohol use disorder).

Conclusion

Presurgical outpatient evaluation by the CL service can allow for risk stratification, review of treatment, and the ability to prepare medical and nursing staff for psychiatrically complex surgical patients.

References

Available on request.