Observation of Cases of Hanging Treated in Medical Wards

Sir,

Hanging is considered as a quickest mode of death for which it is recommended for capital punishment and often chosen for suicidal purpose. However we receive cases of hanging released alive for treatment. Treatment of such cases need ICU set up, but such facilities are always not available.

We observed twenty cases of hanging over a period of six years of which 14 were males and six females. All were below fifty years of age. They used plastic ropes, jute ropes, dhotis, and sarees. Five of the females used sarees; suggesting that object used for ligature depends on accessibility to the object. All these cases happened in peridomestic areas like bath room, bed room, trees in the back yard. Similar observation has been made by others too.1 This is obvious that if cases of hanging have to be saved they have to be released within minutes and this is possible only when somebody is there around. This chance is not there if hanging is attempted in a lonely place.

Clinical features at the time of admission varied. All cases had altered sensorium. Level of consciousness varied from confused to coma (Glasgow coma scale: 5 to 11). The other major findings were cyanosis 70%, respiratory distress (70%), suffused face (90%), convulsion (25%). CNS examination revealed congested retinal veins (90%), absent brainstem reflexes (60%) and decerebrate posturing (20%). CT scan was done in four cases which showed cerebral oedema. X-ray of the cervical spine did not show fracture in any case. Others have also not found any fracture of the cervical spine or spinal cord injury (in postmortem examination also).1,2 Various types of injury to the upper airway have not been noticed by others including separation of the trachea from the larynx; but we did not get any major injury. Injury to the upper airway is more commonly seen in lethal cases.3

Oxygen inhalation was given to all cases. Endotracheal intubation was done in cases having upper airway obstruction. Neck was fixed externally. Nutrition was maintained by nasogastric feeding. Measures to reduce intracerebral pressure were taken in all cases. We preferred Dexamethasone injection to mannitol as it also had anti-inflammatory action at the local site. Other treatment was given as per requirement like antibiotics, anticonvulsants etc. In 17 cases brain stem reflexes returned within 72 hours and all these cases regained consciousness by 7th day. One case died on 6th day and one case died on 7th day. In both the cases brain stem reflexes did not returned till death, both the cases showed decerebrate posture from the beginning. One case remained in a vegetative state for about three months, but ultimately showed marked improvement though remained a bit dementic till six months of follow-up. Except this we did not get any residual neurological deficit though various types of residual neurological deficit have been described.4

We observed that both the cases who died used plastic ropes, in both the cases brain stem reflexes did not return till death. We also observed that return of the brain stem reflexes within 72 hours carried good prognosis. Low Glasgow coma scale always did not carry bad prognosis. This has also been observed by others.2,3 We conclude that though these cases should be treated in ICU, but when such facilities are not there, these cases can also be treated satisfactorily as we have done. Maintenance of airway, oxygenation, measures to reduce cerebral oedema and general care are the main forms of treatment. Return of brain stem reflex can be used as a prognostic factor. One should not be disheartened by a low Glasgow coma scale. A chance of having fracture of the cervical spine is negligible.

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