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Letter to the editor

No fixed abode patients in the emergency department

Sir,– We present the case of a 35-year-old man of no fixed abode who presented as a confusional state in an Emergency Department, following a number of grand-mal convulsions. He was a known epileptic with a history of alcohol abuse and prison confinement, and was felt by the medical staff to be malingering. This diagnosis was based on his unusual presentation, and on the fact that his previous history predisposed him to abnormal behaviour. This judgemental approach meant that a fracture of the skull was missed and important neurological findings were overlooked.

Case: A 35-year-old man, was seen in the Emergency Room following a succession of grand-mal seizures. The first of these had occurred in his brother's home, and the patient was admitted to hospital overnight, and was discharged on the following day. That night, at home, he had a second major fit. This was followed by a period of inappropriate behaviour which warranted transfer to hospital. The medical staff considered that he was malingering and sought a psychiatric opinion.

A collateral history revealed that he had recently returned to Ireland from Britain. He had been deported following his release from prison, where he had spent several months. The rest of his stay in Britain was vaguely recounted, but he certainly abused alcohol and slept rough. His epilepsy dated from a farming accident at age 10 years, and it had been well controlled on phenytoin medication, which he took regularly. His family assured us that he had been compliant with his treatment since his return from Britain.

Mental state examination revealed lability of affect and pressure of speech, and the impression was given of active hallucinosis. Physical examination showed an intermittent strabismus but no other positive findings. In view of this finding and the history of vagrancy, alcohol abuse and prison confinement, a skull x-ray was performed. This showed a long, linear fracture extending from the parietal to the occipital area in the mid-line. He was confined to bed for 72 hours, his neurological status was monitored, and he was started on carbamazepine therapy. His condition resolved over a period of one week. He was subsequently discharged and remained well at last follow-up.

Discussion: Acute psychoses are well documented following both increased epileptic activity, and head injury.[1,2,3,4,5] In this case the increased epileptic activity resulted from a head injury, a phenomenon which is not uncommon. An unusual presentation in a known epileptic may thus produce diagnostic problems, but these are generally readily resolved. The dismissal in this case of the patient's signs and symptoms appears to have been facilitated by his previous vagrancy.

Our case highlights the problems of dealing with NFA patients, especially those with pre-existing medical conditions.[6] Their lifestyle exposes them to more trauma. They have an increased incidence of alcohol related problems, and of other physical and mental illness.[7] Epilepsy in such cases is a particular problem area, with lack of compliance, alcohol abuse and irregular sleep patterns helping to compound their difficulties. The plight of those with no fixed abode (NFA) cannot be underestimated.

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