

Attempted Suicide by Cutthroat Laceration and Medication Overdose: A Case Report and Review of Current Literature

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Abstract

Background: Suicide rates continue to rise in the United States, with the majority increase being males with firearms. Drug-related suicides continue to rise as well, with overall drug overdose mortality increasing fivefold in the last 2 decades. Around 1.8% of trauma admissions are related to suicide attempts, with 30% of these occurring in the head and neck region. Self-inflicted cutthroat lacerations are a rare trauma mechanism. The management of these injuries, especially in zone II of the neck can be challenging. Timely identification and management of injuries in this zone are critical in limiting morbidity and mortality. Furthermore, concomitant drug overdose management may be necessary in the acute post-trauma setting. Toxicology interventions are not common practices in the trauma surgeon's world, but are significant when providing comprehensive critical care.

Case report: We share a case of a 50-year-old male with an ear-to-ear cutthroat laceration in zone II of the anterior neck, further complicated by medication overdose. Patient presented in distress, was taken to the operating room emergently for exploration and was discharged on postoperative day 7 without complication from his injury. We focus on the operative and postoperative management. We also include a brief review of concomitant toxicology management as these suicide attempt modalities are typically complicated by one another.

Conclusion: Self-inflicted cutthroat lacerations are a rare form of penetrating neck trauma. These mechanisms have an elevated level of morbidity and mortality. Prompt operative investigation of associated injured structures is crucial for patient outcomes. These patients are further complicated by ingestion of toxic levels of medications and recreational drugs, for which the trauma team must be knowledgeable in treating.

Keywords: Neck trauma • Penetration injury • Cutthroat • Overdose • Suicide

Introduction

Suicide rates continue to rise in the United States, with the majority increase being males with firearms [1]. Drug-related suicides continue to rise as well, with overall drug overdose mortality increasing fivefold in the last 2 decades [2]. Around 1.8% of trauma admissions are related to suicide attempts, with 30% of these occurring in the head and neck region [3,4]. Self-inflicted cutthroat lacerations are a rare trauma mechanism [5]. The management of these injuries, especially in zone II of the neck can be challenging [6]. Timely identification and management of injuries in this zone are critical in limiting morbidity and mortality. Furthermore, concomitant drug overdose management may be necessary in the acute post-trauma setting [7,8]. Toxicology is less familiar to trauma surgeons and cannot be neglected when providing critical care (Figure 1).

Case Presentation

Trauma bay

A 50-year-old male with a past medical history of anxiety and panic attacks presented as a trauma activation after attempting suicide by knife.

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Patient just prior to attempt ingested 30 tablets of 100 mg trazodone and 8 tablets clonazepam 2.5 mg. The patient first cut his right wrist transversely approximately 4 cm and then proceeded with cutting his anterior neck approximately 22 cm in length. Patient was transported via ambulance to the trauma bay. Patient arrived normotensive, non-tachycardic, saturating 99% on room air and GCS of 15. Patient was noted to have venous hemorrhage, but no active arterial pulsatile bleeding at that time. Patient's airway was secured with endotracheal intubation and patient was taken emergently to the operating room for exploration.

Operating room

In the operating room the patient was placed in the supine position. The laceration was noted to be from ear to ear at the level of the thyroid cartilage, measuring at least 22 cm in length. There was violation of the platysma along the entire laceration with exposed muscle. The wound was explored for major bleeding vessels; one small unnamed arterial branch was ligated on the right lateral side of the laceration. There were bleeding veins throughout the entire wound that were controlled with electrocautery. Next, excisional debridement was performed of non-viable skin, subcutaneous fat, fascia and muscle. The wound was then irrigated. For closure, the 22 cm incision was closed in multiple layers. The platysma was closed first with absorbable suture. A penrose drain was then placed superficial to the platysma. The dermis and skin were then closed with absorbable suture.

To evaluate the esophagus, an upper endoscopy was performed in the operating room. The gastroscope was introduced into the esophagus under direct visualization. The stomach mucosa was examined thoroughly including retroflexion, no additional pathology was found. There were no remnants of any undigested food or medications. The gastroscope was then slowly retracted into the esophagus and the mucosa was examined circumferentially while retracting the scope. No other pathology was seen. To evaluate the trachea, a bronchoscopy was performed in the operating room. The bronchoscope was advanced to the carina and then further into the right main and left main bronchi,



Figure 1. Self-inflicted anterior neck laceration in the trauma bay. Approximately 22 cm in length with complete violation of platysma. Larynx is exposed. Multiple hesitation marks appreciated inferior to main laceration.

no other pathology identified. The endotracheal tube was then retracted several centimeters to allow circumferential examination of the superior trachea. No further injuries identified and the endotracheal tube was advanced back to the correct position. This concluded the end of the case.

Postoperative course

Patient was admitted to the Surgical Trauma Intensive Care Unit (STICU) immediately postop for ventilatory management and continuous telemetry monitoring. Patient was given activated charcoal with polyethylene glycol for his overdose on trazodone and clonazepam. Patient in the first 12 hours best Glasgow Coma Scale Score was 10 with intermittent periods of apnea. Patient's sedation and analgesia were paused at that time. Patient remained intubated on postoperative day 1 until 18 hours postop due to continued periods of apnea while on pressure support. Postoperative day 2 patient was extubated on room air and tolerating a regular diet without dysphagia. Postoperative day 3 patient was transferred to the floor. Postoperative day 5, patient was evaluated by the psychiatry team and the clonazepam taper was completed. The penrose drain was also removed on this day. Postoperative day 6, patient was started on olanzapine. Postoperative day 7 patient was discharged home. Patient was seen in clinic 2 months postop, noted to be doing well, with a well-healed incision with no active issues. A referral was placed to plastic surgery for elective scar revision.

Discussion

Suicide rates continue to rise in the United States. Self-inflicted injury by firearm remains the most common mechanism of penetrating trauma in suicide, contributing to over half of all deaths, with a growth rate that trails only slightly behind overall suicide increases. In contrast, death from self-inflicted injuries by sharp object are far less common but have grown disproportionately rapidly over the past two decades, at more than double the rate of overall suicide deaths [1,2]. Age-adjusted suicide mortality from all mechanisms rose from 10.71 to 14.03 per 100,000 people between 2001 and 2021, a 31% increase. Suicide by firearm rose 27% in the same period, from 5.9 to 7.5 per 100,000, while cutting/piercing increased by 69%, from 0.16 to 0.27 per 100,000. Rates of suicide by primary drug overdose have risen more modestly, with crude mortality increasing from 1.2 to 1.3 per 100,000 between 2001 and 2021 [1]. By contrast, age-adjusted mortality for overall drug overdose increased fivefold in that time, from 6.8 to 32.4 per 100,000 [2]. Penetrating neck injuries carry a higher level of morbidity and mortality due to the density of vital structures with lack of musculoskeletal protection. The neck region was classically divided into 3 anatomic zones. Zone I from the clavicles and sternal notch to the cricoid cartilage. Zone II between the cricoid cartilage and the angle of the

mandible. Zone III from the angle of the mandible to the base of the skull. The zones were described to be used to try and predict what structures were at risk of injury. Zone I includes the large vascular structures of the superior mediastinum, the innominate and subclavian vessels, internal jugular veins, carotid arteries, esophagus and trachea. Zone II includes the carotid arteries, the vertebral arteries, internal jugular veins, trachea and esophagus. Zone II is most accessible for the trauma surgeon to intervene on. Zone III includes distal carotid arteries, jugular veins, distal vertebral arteries and the oropharynx. Of note, Zone III injuries are anatomically challenging for surgeons to reach and are therefore not typically explored open [9]. This patient presented with a Zone II injury with bleeding and violation of the platysma along the entire 22 cm incision. It was crucial to rule out injuries to the aerodigestive tract and major vessels. In penetrating neck trauma cases the incidence of vascular injury is up to 25% and aerodigestive tract injury up to 30% [9]. As this patient had active bleeding, they were taken to the operating room emergently for exploration and were further assessed with bronchoscopy and upper endoscopy. This case was further complicated by home-medication overdose. Self-inflicted lacerations to the neck are managed through the ATLS algorithm, with workup and operative exploration as indicated. Concomitant drug overdose, as in this case, is a complicating factor of patient care in the perioperative trauma bay and STICU settings. One analysis of the CDC's National Violent Death Reporting System (NVDRS), which includes toxicology, coroner and law enforcement reports, showed that prescription or illicit drugs were present in 22% of firearm suicides, most often benzodiazepines and opioids [7]. These findings highlight that drug ingestion is frequently present even when overdose is not the primary mechanism of suicide, although inconsistent practices of toxicology testing likely underestimates prevalence and misrepresents distribution of each specific drug class. Suicide by drug intoxication alone is likely profoundly under-reported in cases in absence of a suicide note, previous attempt, or depression history, especially in comparison to suicide by firearms and hanging [10].

Combined, these findings suggest that non-poisoning suicide methods, in our case penetrating self-inflicted cutthroat laceration, can potentially obscure drug presence or concurrent overdose. For this reason, diligence on the part of the trauma surgeon and accompanying team to the toxicological status and potential complications in their patients is warranted in the perioperative management of self-inflicted penetrating trauma. For the case discussed in this report, presentation of the patient's self-inflicted neck injury was concomitant with ingestion of 30 tablets of 100 mg trazodone and 8 2.5 mg clonazepam tablets prior to suicide attempt via laceration. The total 3-gram dosage of trazodone is well above the maximum FDA-approved label of 600 mg for inpatient major depression and is also the most frequent dose associated with emergency department treatment and discharge in the United States [11]. It further exceeds the median dose of 1.5 g associated with ICU admission

for major effects such as Central Nervous System (CNS) depression, cardiac arrhythmia and hypotension [12]. Although isolated overdose of benzodiazepines such as clonazepam is rarely associated with mortality, they are frequently co-ingested with other central nervous system depressants such as alcohol, opioids and in this case, antidepressants like trazodone [13]. The combination of trazodone and clonazepam in this patient is clinically significant in the context of trauma surgical management because of their synergistic CNS and respiratory depressant effects. For this reason, airway protection and postoperative ventilatory management are of particular importance in patients with suspected sedative co-ingestion. In this case, the patient required mechanical ventilation for approximately 18 hours postoperatively due to recurrent apneic episodes on pressure support, consistent with delayed recovery from combined drug intoxication.

In the context of the patient's overall management, airway protection was prioritized immediately, consistent with the Advanced Trauma Life Support

(ATLS) principles for traumatic neck injury as well as standard practice in cases of drug-related respiratory depression [14]. After surgical exploration and repair, further toxicological management was undertaken in the STICU with activated charcoal to adsorb ingested drug and whole bowel irrigation with Polyethylene Glycol (PEG) to enhance gastrointestinal clearance of unabsorbed drug, both established decontamination strategies in large ingestions once the airway is secured [15,16]. These interventions, combined with close ventilatory monitoring at the ICU level, aimed to limit further absorption of the ingested drugs and mitigate delayed toxicologic manifestations of respiratory and CNS depression. These toxicology interventions are not common practices in the trauma surgeon's world, but are significant when providing comprehensive critical care. To place this case in broader context, Table 1 below summarizes common drug classes implicated in suicidal overdose, their characteristic toxidromes and management strategies relevant to trauma and ICU care, adapted from prior epidemiological analyses [17,18].

Table 1. Common drug classes implicated in suicidal overdose, their characteristic toxidromes and management strategies relevant to trauma and ICU care [17,18].

Drug/Class	Common Agents	Clinical Features/Toxidrome	Standard Management	Additional Trauma/ICU Considerations
Opioids	Heroin, Morphine, Oxycodone, Fentanyl	Opioid toxidrome: Respiratory depression, miosis, altered mental status, hypotension	Airway protection/ventilatory support, Naloxone (IV or intranasal)	Respiratory depression may mimic hypoventilation from neck/chest trauma. Naloxone can cause acute withdrawal + agitation complicating airway/surgical management.
Benzodiazepines	Clonazepam, Alprazolam, Lorazepam, Diazepam	Sedative-hypnotic toxidrome: Respiratory depression, sedation, ataxia	Supportive care (possible intubation for airway); Consider Flumazenil for non-habituated users such as pediatric patients; avoid otherwise for risk of seizure, dysrhythmia, and withdrawal syndrome precipitation.	Depressed GCS complicates neuro exam after head/neck trauma. Respiratory depression increases aspiration risk in facial/airway trauma.
Antidepressants	TCAs (amitriptyline), SSRIs (fluoxetine, sertraline), Trazodone	Serotonergic toxidrome (SSRI/SNRI/trazodone, etc.): AMS, hyperthermia, clonus, hyperreflexia. Anticholinergic toxidrome (TCAs): Cardiotoxicity (QRS widening, arrhythmias) + delirium, dry skin, mydriasis, urinary retention.	Activated charcoal, cardiac monitoring, sodium bicarbonate (for TCA arrhythmias)	TCA cardiotoxicity (QRS widening, arrhythmias) can mimic traumatic cardiac injury. Anticholinergic effects (urinary retention, ileus) complicate abdominal trauma/post-op care. Seizures may mimic post-traumatic seizure activity.
Antipsychotics	Haloperidol, Risperidone, Olanzapine, Quetiapine, Clozapine	Neuroleptic toxidrome: When severe, delayed onset of Neuroleptic Malignant Syndrome (fever, rigidity, altered mental status, + autonomic instability). Milder - Extrapyramidal symptoms, most acutely with dystonia.	For Neuroleptic Malignant Syndrome (NMS): aggressive supportive care, cooling, fluids, continuous monitoring for QT prolongation, consider dantrolene or bromocriptine. For ExtraPyramidal Symptoms (EPS): acute dystonia: benztropine/diphenhydramine.	NMS/hyperthermia may be confused with infection or malignant hyperthermia. EPS can be mistaken for CNS injury. QT prolongation/arrhythmias complicate trauma resuscitation.
Alcohol	Ethanol	Sedative-hypnotic toxidrome as above. Additional risk of aspiration and metabolic derangement acutely; with seizure, delirium tremens, and autonomic stability with post-toxicity withdrawal.	Supportive care with airway protection, fluids, vitals monitoring, and correction of hypoglycemia/electrolyte abnormalities. External rewarming for hypothermia. Benzodiazepines for withdrawal (seizures/DTs).	Acute intoxication lowers GCS + hard to separate from traumatic brain injury. Aspiration risk in facial/airway trauma. Withdrawal (delirium tremens) develops in ICU complicates sedation.
Acetaminophen	Acetaminophen (Tylenol, paracetamol)	Delayed onset hepatotoxicity, nausea/vomiting, RUQ pain	N-Acetyl Cysteine (NAC), activated charcoal if early	Hepatic injury complicates coagulopathy + increased bleeding risk in trauma surgery. Delayed hepatotoxicity may overlap with shock liver.
Barbiturates	Phenobarbital, Pentobarbital, Butalbital	Sedative-hypnotic toxidrome as above. Additional risk of cardiovascular collapse, hypothermia, and more severe respiratory failure.	Airway/ventilatory support if concern for airway protection or progression to respiratory failure. IV fluids + vasopressors for hypotension, external rewarming for hypothermia, consider Naloxone IV/intranasal for concurrent opioid toxicity concern.	Profound CNS/respiratory depression mimics severe TBI. Hypotension complicates differentiation from hemorrhagic shock.
Psychostimulants and Cocaine	Amphetamine, Methamphetamine, MDMA, Cocaine	Sympathomimetic toxidrome: Hypertension, tachycardia, hyperthermia, agitation/paranoia, hallucinations, mydriasis, tremor, diaphoresis; in severe cases seizures and rhabdomyolysis. *Cocaine additionally associated with myocardial ischemia, QRS widening, and arrhythmia by Na ⁺ blockade.	Benzodiazepines, beta-blockers, antiarrhythmic agents, and antihypertensive medications. *For beta-blockers contraindicated and agitation.	Agitation may hinder airway/surgical management. Hypertension, tachyarrhythmias increase risk of intraoperative cardiac events. Cocaine Na ⁺ channel blockade + arrhythmias that mimic blunt cardiac trauma.
NSAIDs (group Ibuprofen/salicylates)	Ibuprofen, Naproxen, Aspirin	In severe cases: AKI, GI hemorrhage, metabolic acidosis, and CNS depression/seizures.	Activated charcoal if <2 hours since exposure; Airway protection, IV fluids for renal protection, hemodynamic monitoring for GI hemorrhage.	Platelet dysfunction increases bleeding risk in penetrating injuries. Salicylate toxicity metabolic acidosis complicates resuscitation.

Calcium channel blockers	Verapamil, Diltiazem, Amlodipine	Hypotension, bradycardia/AV block with hyperglycemia. Severe cases: cardiogenic shock, metabolic acidosis, seizures, and end-organ ischemia.	Airway management/ICU monitoring. Activated charcoal if ≤ 2 h (≤ 4 h if large ingestion/sustained release); Whole Bowel Irrigation (WBI) via polyethylene glycol for sustained-release products; IV calcium boluses; High-Dose Insulin Euglycemia (HIE) (w/ dextrose + K+). Vasopressors for refractory hypotension. Rescue: lipid emulsion, glucagon, pacing/ECMO.	Drug-induced shock may mimic hemorrhagic shock. Hyperglycemia confounds metabolic monitoring. Bradycardia/AV block complicates intraoperative cardiac management.
Beta-blockers	Propranolol, Metoprolol, Atenolol	Hypotension, bradycardia, AV block, with hypoglycemia. Increased severity: Cardiogenic shock, seizures (higher with lipophilicity - propranolol), QRS refractory hypotension, QTc prolongation/torsades (sotalol).	Airway management/ICU monitoring. Activated charcoal if ≤ 2 h (≤ 4 h and WBI indicated for large ingestion/sustained release). Glucagon bolus/infusion; calcium for hypotension. High-Dose Insulin Euglycemia (HIE) (w/ dextrose + K+). Sodium bicarb (QRS), Mg^{2+} (torsades). Vasopressors for refractory hypotension. Rescue: lipid emulsion for highly lipophilic beta-blockers (propranolol), HIE (atenolol/sotalol), ECMO.	Severe bradycardia/hypotension confuses trauma team with hemorrhage or neurogenic shock. Hypoglycemia masks stress hyperglycemia response to trauma. Seizures (lipophilic BBs) mimic TBI.
Antidiabetics	Insulin, Sulfonylureas, Metformin	Insulin/Sulfonylureas: Hypoglycemia (AMS, seizures, coma, diaphoresis, tachycardia). Metformin (biguanide): GI upset, lactic acidosis, shock.	Insulin/Sulfonylureas: IV dextrose bolus & infusion, with frequent glucose checks. Consider octreotide for sulfonylurea-induced hypoglycemia. Metformin: Activated charcoal for recent ingestion/extended release.	Hypoglycemia mimics altered mental status from TBI or shock. Metformin lactic acidosis complicates resuscitation and ICU acid-base management. Requires frequent glucose checks perioperatively.
Antiepileptics	Valproic acid, Carbamazepine, Phenytoin, Lamotrigine	CNS depression/ataxia shared. Other clinical signs are drug dependent.	Activated Charcoal (MDAC) indicated if recent ingestion. Massive Dose Activated Charcoal (MDAC) indicated for carbamazepine/phenobarbital. Supportive care with ICU monitoring. Benzodiazepines for any seizures. Sodium bicarbonate for QRS widening in lamotrigine and carbamazepine. Consider hemodialysis for severe valproate and phenobarbital poisoning.	CNS depression mimicry of post-traumatic encephalopathy. Seizures from toxicity vs. post-traumatic seizure difficult to distinguish.

Conclusion

Self-inflicted cutthroat lacerations are a rare form of penetrating neck trauma. These mechanisms have an elevated level of morbidity and mortality. Prompt operative investigation of associated injured structures is crucial for patient outcomes. These patients are further complicated by ingestion of toxic levels of medications and recreational drugs, for which the trauma team must be knowledgeable in treating.

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Conflict of Interest

None

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