Multi-Disciplinary Approach to Managing Deliberate Foreign Body Ingestion on the Medical Floor

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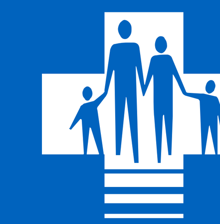

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BACKGROUND

- Deliberate foreign body ingestion (DFBI) accounts for 1500 deaths per year, 92% of which are intentional. This incurs approximately $6,000 per hospital visit in the United States, with an average hospital stay of 5.66 days.
- The disorder has a complex pathophysiology, often co-morbid with severe personality disorders, PTSD, and some psychotic disorders.
- Little is known about the psychiatric management of this behavior and additional studies are needed to outline best practices around DFBI in the hospital setting.

CASE

NH is a 29-year-old patient with past psychiatric history of borderline personality disorder, PTSD, and extensive self-harm history who presented to the hospital after ingestion of 30 thumb tacks and 2 batteries impulsively due to acute distress.

Psychotropic Medications
Prazosin 3 mg qhs
Mirtazapine 30 mg qhs
Fluoxetine 40 mg qd
Chlorpromazine 100 mg TID
Quetiapine 300 mg qhs
Lorazepam 1 mg TID
Zolpidem 15 mg qhs
Methylphenidate 54 mg qAM
Methylphenidate 36 mg daily at 2PM

Past Medical History
Hypothyoidism
Graves' disease
History of neurogenic bladder requiring
intermittent self-catheterization
Addison's disease

DIAGNOSTIC IMAGING

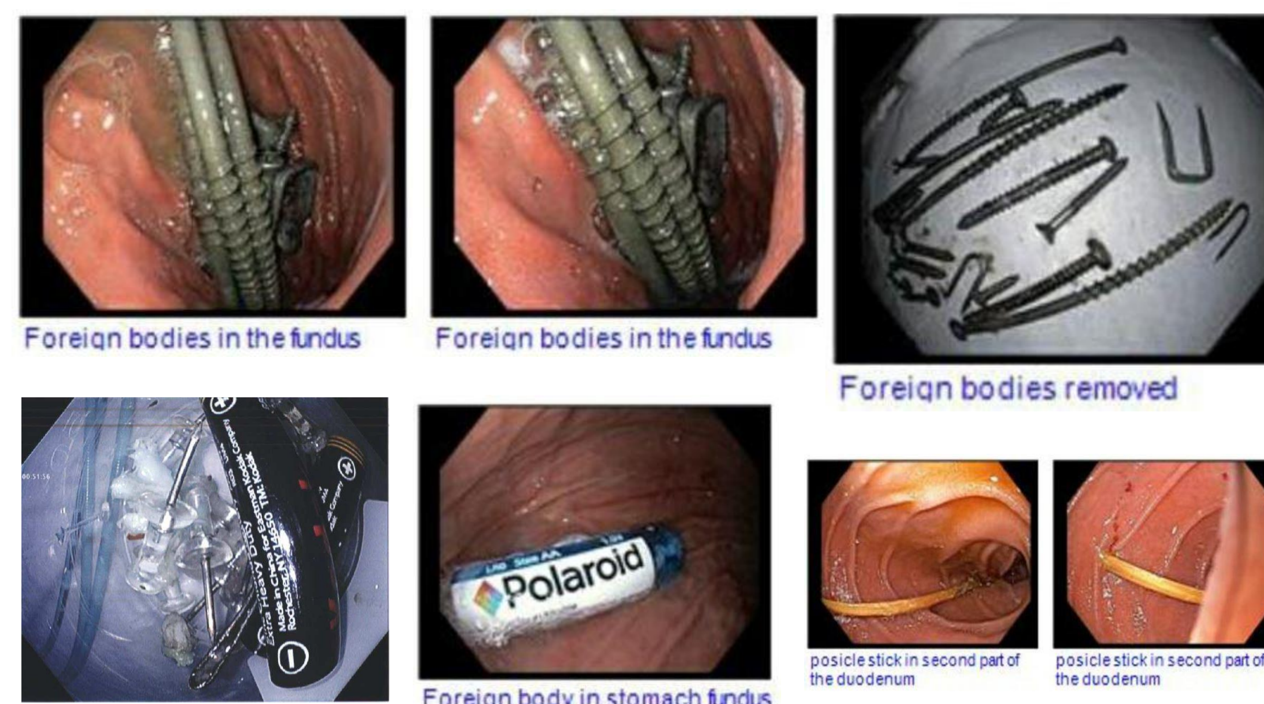
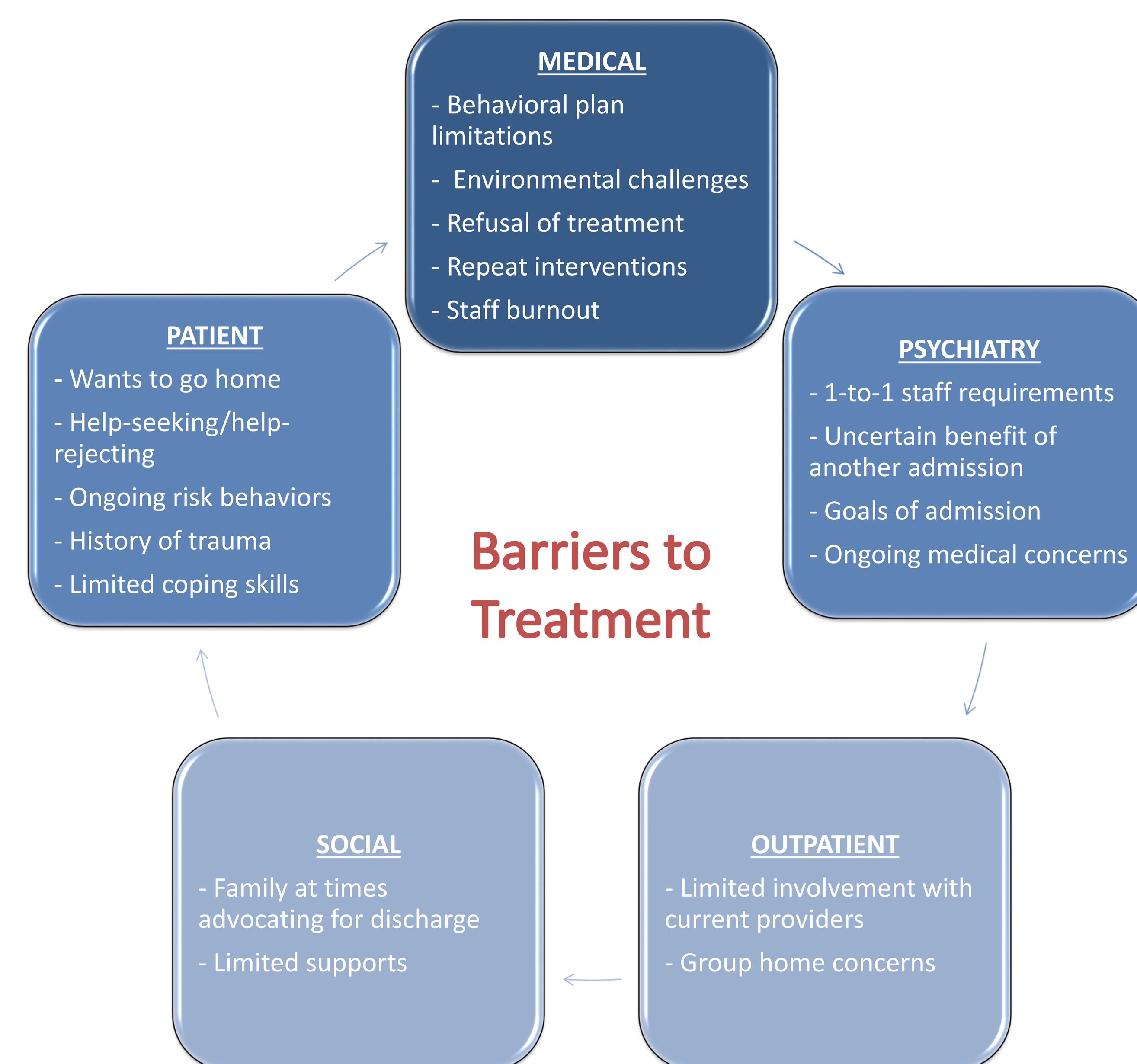


Fig. 1-7: Endoscopy images.



HOSPITAL COURSE

AUG 2021:

- Admitted with plan for serial daily KUBs to make sure all the foreign bodies have passed
- Constant Companion ordered
- Behavioral Resource Team (BRT) involved, working on behavioral plan
- Ongoing swallowing of metal hook, mask wire and putting foreign body in vagina
- OBGYN removes tampon/soft objects
- Minimal oral intake
- NH is "medically cleared", all objects have passed
- Crisis team meets with NH and is made a psychiatric bed search

SEPT 2021:

- NH begins ingesting popsicle sticks (multiple EGDs)
- NH continues to endorse vaginal packing and multiple small soft objects removed
- NH continues with minimal oral intake, no BM, abdominal pain, new wires on Xray
- NH continues to deny SI or depression, advocating for discharge
- Group home and community supports want IPLOC
- Inpatient psychiatry not able to accommodate until single bed opened
- Eventually psychiatric bed search is stopped due to medical issues

OCT 2021:

- NH has stopped most of her psychiatric medications for weeks
- Multiple meetings held between inpatient, outpatient and Crisis team
- Group home reports they cannot manage her behaviors
- NH agreeable to plan for home with PHP
- By early October, NH is taking her medications, no recent ingestion/swallowing or packing
- NH's family (mother/fiancée) advocate for discharge to their care
- NH is discharged to family care and next day PHP enrollment

DISCUSSION AND CONCLUSIONS

- Effective treatment approaches to DFBI are multidisciplinary.
- The decision to pursue placement in an inpatient psychiatric unit should be carefully weighed against the potential for impairing treatment progress.
- A care plan can be vital in protecting the patient and managing staff expectations and countertransference; it may also have financial benefits due to shorter duration of admission.
- Shared management across providers, including emergency medicine, consultation-liaison psychiatry, gastroenterology, poison control, and potentially the hospital bioethics board.
- A care plan can help alleviate symptoms of physician burnout and facilitate comprehensive and patient-centered care.

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