Psychopathophagia: A Hard Syndrome to Swallow!

Deliberate Foreign Body Ingestion
Presentation for APNA Annual Conference
October 20, 2016
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Statement of Disclosure

• The speaker has no conflicts of interest to disclose

Learning Objectives

• Describe the clinical presentation of psychiatric patients who exhibit deliberate foreign body ingestion, more commonly called, swallowing disorder.
• Discuss challenges of caring for patients who exhibit deliberate foreign body ingestion.
• Explore interventions for effective care management on the nursing and interdisciplinary team level for patients who exhibit deliberate foreign body ingestion.
“Psychopathophagia” Defined

- Medical Terminology Breakdown:
  - Psych = mind
  - Path = disease
  - Phagia = pertaining to swallowing
  - “A psychiatric disorder which involves pathological swallowing”
  - Commonly referred to as Deliberate Foreign Body Ingestion (DFBI) or Atypical Swallowing Disorder
  - Even more casually describe the patient as a “Swallower”

Diagnostic Considerations

- No specific DSM-5 psychiatric diagnosis label
- Swallowing behavior often associated with an underlying psychiatric diagnosis or pathology, such as a personality disorder, schizophrenia, obsessive-compulsive disorder, feeding disorder
- May be considered a psychosomatic syndrome or a factitious disorder
- Often has a para-suicidal or self-harm intent
- Type of Munchausen syndrome
  (Source: Gitlin, D. et al., 2007)

Psychopathophagia Has Become:

- One of the most intriguing, yet least understood psychiatric syndromes of all time
- More prevalent, especially in the United States and Canada, but occurs internationally and across diverse cultures
  - 80,000 Emergency Room visits recorded at one university tertiary hospital setting in one year and this # is rising
  - Increasingly dangerous and life-threatening
  - 1500 Deaths annually in US secondary to foreign body ingestion
  - Risks of accidental ingestion include: intoxication, dental surgery, visually impaired, young children and infants, bulimia nervosa
- Extremely costly for the health care system
- Highly challenging for nurses and healthcare providers
  (Source: Kijewski, V., 2012)
Historical Perspectives

- Deliberate Foreign Body Ingestion is assumed to be a psychiatric condition that has existed for many years, although has not been specifically documented
- Evidence of it existing in the early 1900s
- Patient at Saint Joseph’s Insane Asylum, Missouri in 1929
- Compulsion for swallowing objects other than food
- Patient became acutely ill and an x-ray plate of the abdomen revealed a vast accumulation of objects, including nails, screws, bolts, nuts, buttons, thimbles, safety pins…
- Total of 1,446 objects were surgically removed
- Fatal outcome, as the patient died during surgery (Source: Glore Psychiatric Museum)

Deliberate Foreign Body Ingestion

- Adult Foreign Body Ingestion (FBI) presentations are
  - 92% deliberate; 84% previous hx; 85% prior psychiatric dx
  - In 64% of cases, the time of ingestion to clinical presentation was > 48 hours
  - Estimated 80-90% of objects will pass spontaneously
  - 10-20% require endoscopy
  - 1% require surgical intervention
  - Substantial health consequences, medical and psychological
  - Risk of injury is serious
  (Source: Poynter, B. et al., 2011)
Deliberate Foreign Body Ingestion

- Procedural Interventions and Outcomes
- Research involving a retrospective study of 262 DFBI cases in an urban county hospital
  - Endoscopic extraction: 90% success rate (165/183 cases)
  - Surgery performed in 11% of the cases (30)
    - More common for objects beyond the pylorus (37%) vs objects above the pylorus (7%)
    - Required for cases with a greater delay from ingestion to presentation and from presentation to intervention
  - Perforation occurred in 6% of the cases (16), with 6 of them noted after endoscopy
  - Long delays from ingestion to presentation and intervention may result in surgical intervention and risk of perforation
    (Source: Palta, R. et al., 2009)

Research and Etiological Categories of DFBI

- DFBI related literature primarily from the medical-surgical and emergency treatment perspectives
- Paucity of research regarding efficacious and long-term psychiatric and psychological management of these patients
- Literature search of 2432 primary articles: 74 psychiatric related
- Four primary categories identified from the research
  - 1. Pica
  - 2. Psychosis
  - 3. Malingering
  - 4. Severe Personality Disorders, such as Borderline and Antisocial Personality Disorder
  - Essential to treat the underlying psychiatric diagnosis of DFBI
    (Source: Gitlin, D. et al., 2007, and Poynter, B. et al., 2011)

PICA

- Classified as a feeding disorder in DSM-5
- Repeated eating of nonnutritive substances
- More common in the pediatric population
- Can persist into adulthood
- Frequently associated with
  - Intellectual Disabilities
  - Autism Spectrum Disorder
  - Cognitive Impairment
  - Sometimes difficult to distinguish from Obsessive-Compulsive Disorder (OCD)
  - Nutritional deficiency, such as low iron and anemia
    (Source: Gitlin, D. et al., 2007)
Psychosis

- May be secondary to delusional beliefs or command hallucinations
- Patients often swallow high number of objects
- May not inform others about the ingestion, and not discovered until GI distress occurs
- Psychiatric follow-up and treatment with antipsychotic medication
- Treat the underlying psychosis and stabilize condition

(Source: Gitlin, D. et al., 2007, and Poynter, B. et al., 2011)

Psychosis

- Case reports of patients with schizophrenia
  - One patient died secondary to zinc intoxication after swallowing 461 coins
  - One patient required treatment for lead poisoning after swallowing 206 bullets
  - 24-year old male presented with acute gastrointestinal bleeding led to emergency laparotomy and gastrostomy which removed over 50 metallic objects from the stomach
  - Ingestion of a rolled, metal tuna can lid related to command hallucinations
  - 21-year old female with religious delusions swallowed a door key while undergoing clinical investigations at a hospital
  - Male patient swallowed cigarette lighter, batteries, coins, paper $, and gold/diamond jewelry

(Source: Gitlin, D. et al., 2007, and Poynter, B. et al., 2011)

Malingering

- Swallowing act benefits the individual in some obvious way, considered a factitious disorder
- Most often seen in prisons, psychiatric institutions
- Leads them to being transferred to more “comfortable” surroundings of a hospital or being able to access medications
- One study reported 66.9% cases were jail inmates at the time of ingestion
- Items swallowed include razor blades, screws, nuts, and bolts
- “Gastrointestinal crosses”, manufactured from broken paper clips, paper, and rubber bands specifically designed to spring open during GI transit, causing perforation of the bowel wall, so that more extreme and urgent care is prompted

(Source: Gitlin, D. et al., 2007)
Severe Personality Disorders

- Primarily Borderline and Antisocial Personality Disorders
- Repeatedly engage in DFBI, sometimes at frequent intervals, as swallowing behavior can occur in "runs"
- Swallowing involves dramatic, parasuicidal, and self-harm behavior
- Impulsive or premeditated; often manipulative
- May not be immediately apparent to the physician, and patient may present with variety of chief complaints, ranging from direct report of the ingestion to a vague account of abdominal pain or nausea
- Treatment providers may think that they are being "held hostage" until foreign object is safely passed or retrieved
- Patients usually well known to staff from multiple presentations in the past and most challenging case presentations

(Source: Gitlin, D. et al., 2007)

General Care Management Principles

- Establish a safe environment
- Manage medical or surgical consequences of present episode
- Assess causative factors and triggers of the swallowing
- Attempt to reduce the frequency of future swallowing behavior
- Implement a consistent nursing care plan for the patient
- Manage inevitable countertransference experienced by caregivers
- Address wider institutional issues for collaborative and united care

(Source: Poynter, B. et al., 2011)

Establish a Safe Environment

- Keep milieu and treatment setting safe for patient
  - Removal of objects in environment
    - Batteries, silverware, pens, toothbrushes, plastic med cups, cell phones...
  - Medical or surgical instruments
  - Suicide and Self-harm Precautions and Constant Observation
    - Place on 1:1 for close monitoring
    - May require use of seclusion or restraints to keep the patient safe...but use least restrictive means of care possible
  - Limit Setting
    - Clear expectations of appropriate behavior
    - Contract for no episodes of ingestion while inpatient, consider questionable reliability

(Source: Poynter, B. et al., 2011)
Manage Medical or Surgical Consequences

- Urgent assessment for medical or surgical intervention if patient has the following symptoms or problems:
  - Pain
  - Dysphagia
  - Drooling
  - Respiratory distress
  - History of abdominal surgery
  - Elongated/sharp objects or batteries were swallowed
- Less urgent medical attention if
  - No pain
  - Blunt and/or small objects were swallowed
  - Remote history of DFBI
  - Absence of physical symptoms
(Source: Poynter, B. et al., 2011)

Manage Medical or Surgical Consequences

- Review medication or substances that patient has taken
- Assess for anything that may reduce GI motility and slow the passage of the object
- Psychiatric Consultation
  - Should not delay medical management
  - Diagnostic evaluation and clarification
  - Transfer or disposition of the patient
  - Involuntary admission proceedings
  - Assessment of suicidality and self-harm risk
  - Be aware of and manage colleagues’ countertransference reactions
(Source: Poynter, B. et al., 2011)

Risk Reduction of Future of Swallowing Behavior

- If psychiatric inpatient treatment is necessary, advised to keep it at a brief and minimum stay
- Psychiatric Inpatient Hospitalization alone has:
  - Not shown to reduce further episodes of DFBI
  - May foster regression
  - May positively reinforce the swallowing behavior
  - May lead to escalation of swallowing behavior
- If there is no other indication for acute psychiatric hospitalization
  - Explain and discuss options with Emergency Department/GI/Med-Surgical Teams
(Source: Poynter, B. et al., 2011)
Address Wider Institutional Issues

- Collaborative, nonconflictual interdisciplinary management
- Identify difficult, high risk patients
- These cases often evoke intense emotional reactions by care providers
- Involve the Emergency Department, Gastroenterology, Endoscopy and General Medical-Surgery, Intensive Care, Psychiatry- Inpatient/Outpatient, Bioethics Committee, Hospital Legal, Social Work, and Nursing
- Develop comprehensive "model of care" plan for patients with DFBI
- Shown to reduce tension between services and ensures a consistent standard of care
  (Source: Poynter, B. et al., 2011)

Additional Nursing Care Strategies

- Extremely challenging patient care situations with no easy solutions
- Consistency in care approach is highly important to avoid staff "splitting" and gaps where patient can act out
- Clinical supervision and nursing/multidisciplinary health care team meetings may be helpful
- Take proper care of self and maintain self-awareness to support therapeutic use of self
- More research needed to support EBP nursing care
- Additional care strategies???

Question & Answer Session

- What experiences have you had with patients engaging in DFBI?
- What are your feelings and perceptions of patients with a clinical presentation of DFBI?
- What are some of your challenges of caring for this unique psychiatric patient population?
- What interventions or care strategies have you found to be successful vs not so successful with patients who repeatedly engage in DFBI?
- What insights might you share and what areas do we need to further pursue related to clinical research, education, and practice?
References and Further Reading

- Huang, B. et al. (2010). Intentional swallowing of foreign bodies is a recurrent and costly problem that rarely causes endoscopy complications. Gastroenterology Hepatology, 8(11), 941-6.
References and Further Reading
