



# Foreign Body Ingestors: Management Challenges for Consultation Liaison Psychiatrists

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# APM 2014 Disclosure for: Elias Khawam, MD, Syma Dar, MD, Margo Funk, MD, Christopher Sola, DO, Lara Feldman, DO, Karen Salerno, LISW-S

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the parties listed above (and/or spouse/partner) and any for-profit company in the past 24 months which could be considered a conflict of interest

## Background

- Challenging patient population for both psychiatrists as well as our medical colleagues
- Difficult to differentiate non-suicidal SIB from self-injury with suicidal intent
- Common experience to feel the strain of producing an effective assessment and treatment plan while balancing the expectations of medical colleagues, other treatment team members, and outpatient providers.

## We are all in this together...

- How many here have dealt with FBI?
- Personal experiences in treating FBI?
- Specific challenges in dealing with FBI?
- What would be helpful to take away from the workshop today?

# Case 1

## Case 1

- 19 y/o WF with borderline PD
- Recurrent ingestions/admissions, self-mutilating behavior, ? Mood/Bipolar disorder
- Admitted twice for ingestions recently
- Last admission: swallowed objects in ICU
- Now readmitted for ingestion
- 1:1 begun; cannot remove items (too distal)

## Case 1 (continued...)

- While being observed, once again swallowed small object.
- Discussion between CL psych and Nursing, “least restrictive measures.”
- B/L wrist restraints added.
- On evaluation next day, restraints very loose.
- Patient had eyeglasses on.
- 1:1 distracted, friendly with patient.

# Small Group Discussion



# Questions For Small Group Discussion

- How do we balance nursing and CL psych needs?
- What about 1:1 role?
- What is the role of restraints in this case?

# Case 2

## Case 2

- 32 y/o WF with borderline PD presents s/p ingestion of razor blades wrapped with tape.
- 157 hospitalizations in past 9 years.
- GI, Gen Med, Gen Surgery, Psych.
- >100 episodes of razor blade ingestion.
- >40 EGDs
- 3 exploratory laparotomies.
- Complications: esophageal tearing.
- Typically short hospitalizations unless blades cannot be removed → multiple-week stays for blades to pass.

## Past Psychiatric History

- Past dx: schizoaffective d/o, bipolar, PTSD.
- Significant childhood trauma.
- Numerous medication trials:
  - quetiapine, aripiprazole, haloperidol, chlorpromazine, Invega Sustenna, olanzapine
  - carbamazepine, depakote, gabapentin, lamotrigine, lithium, lurasidone
  - acamprosate, naltrexone
  - citalopram, duloxetine
  - Clonazepam.
- Recently fired from ACT team for verbal threats.

# MSE

- Obese, WF, numerous scars from cutting on BL upper extremities.
- Tattoo on left forearm: “Cut here - - - - -”
- Only occasional eye contact, rolls eyes at examiner, looks mostly at telephone, texting.
- “What do you want?”
- Affect is irritable and annoyed.
- Denies SI, HI, AVH.
- Significant attempts at splitting (between teams and within CL team).

# Small Group Discussion

## Questions for Small Group Discussion

- How to manage expectations of GI, surgical teams: “why can’t you prevent her from doing this?”
- How to manage negative countertransference of healthcare team (nurses, other physicians)?
- How to manage differences in approach *within* the CL team?

# Outcomes

- ...Patient remains a high-utilizer in our hospital.
- Psycho-education for teams
  - Emphasize chronicity.
  - Validate frustration.
  - Bring to awareness our tendencies towards avoidance, power struggles, splitting, wanting to “punish” the patient.
  - Plant nuggets of empathy.



# Outcomes

- Behavioral Plan
- Helps us remain consistent (even when we have different general approaches).
  - Limited number of staff who see her.
  - No students or trainees.
  - Pt knows what to expect, including firm limits.
- Initial evaluation to assess for suicidality, if none, discharge back to community.
- If longer medical hospitalization required, stay active with team, but limit pt interaction.

# Case 3

# Introduction

- 37 years old Caucasian male
- Significant history for Borderline and antisocial personality disorders and was also given multiple other diagnosis:
  - Polysubstance abuse: Opioids, benzos, cannabis
  - “Atypical mood and psychotic disorders”
  - Bipolar disorder, MDD
  - Schizophrenia, schizoaffective....
- Multiple psych med trials including antidepressants, antipsychotics and mood stabilizers.....

## Continued.....

- Significant history for violent and aggressive behavior
- Significant history for FBI including:
  - Paperclips
  - Sawblades, razor blades
  - Forks, spoons
  - Paper clips
  - Radio antenna, etc.
- Multiple ED presentations and hospital admissions including presentation ED from Jail s/p swallowing radio antenna: EGD, DC to Jail

## Things went wrong.....

- He was admitted to OSH for swallowing a fork which lead to bowel perforation and gastro-cutaneous fistula.
- He was transferred to CCF and underwent:
  - Laparotomy and closure of a duodenal fistula
  - Followed by limited laparotomy and repair of a duodenal leak
  - Wound VAC was placed and he was continued on TPN and antibiotics.
- Hospital stay: 1.5 months
- Transferred to LTAC: open abdominal wound with a dressing in place, wound VAC

## Bad, bad and bad....

- Hospital course complicated by assaulting staff members and psychiatry resident
- Multiple CITs: police, psychiatry, primary team, nursing staff, and chaplain.
- Psychiatry responded to CIT
  - Pt was verbally assaultive toward nurse. He was in bilateral wrist soft restraints.
  - He was uncooperative but aware of his condition and demanded a port placed.
  - He stated that "everyone was f--ing liars."
  - He was alert and oriented, and did not appear psychotic.
  - **He then kicked me forcefully with his left leg in my stomach, grabbed my pager and threw it at me and RN.**
  - Patient began spitting large amount of phlegm at chaplain, RN, and me. We were able to place masks on chaplain and RN who remained at bedside holding down his left leg. Police arrived, gowned, masked and attempted to restrain patient.

## Not again....

- Readmitted again for aggressive violent behavior, including "attacking" 9 staff member and kicking another...
- Primary team requested psychiatry consult for management of violence, aggression, and fear of recurrent FBI

## Oh my my.....

- Staff psychiatrist interview
  - Patient was tearful, angry, volatile mood, "get the f-- out of here", not cooperative in the interview
  - Verbally aggressive with sitter and nursing staff
  - Patient was redirected and confronted that staff would advocate for his care while in the hospital, but that no verbal, or physical assault to any personnel would be tolerated.
  - **Patient escalated, threatened to assault, and then proceeded to hit staff psychiatrist in the chin.**
  - CIT called, and in presence of police officer, again escalated with pretext "see, send me to jail, go ahead" and punched interviewer again in the chest.
  - Post assaults to interviewer where of low impact, no major harm, but with malicious intent.



## Many complications...

- Medically: refusing IV fluid, refusing meds off/on, ended dehydrated, + infection, ATN, severe protein-calorie malnutrition....
- TPN team refused to start TPN since he has “functional” digestive system
- Manipulating IV lines, removing J-tube, s/p multiple reinsertion
- Demanding IV Ativan and Benadryl
- Demanding IV morphine
- Swallowing behavior off/on. S/p EGDs
- Assaulting nursing staff... "jail is more fun...there are things you can do there".

## Threatening to FBI.....

- CIT: resident intervention: 90 minutes
  - Patient had bitten through his IV line and had an IV clamp in his mouth and refused to give it up.
  - Demanding IV Ativan and Benadryl
  - Spent approximately 90 minutes with the patient and Pt insisted that he did not do this for attention or to manipulate medications out of staff. Recurrent behavior/attention craving. finally had him give up the clamp to me.
- No psychiatry unit accepted the patient
- Finally, demanding to be “FIXED” before discharge

# Small Group Discussion

## Questions for Small Group Discussion

- Best approach for patient violent behavior
  - Would you file charges against patient?
- Best approach for patient's threats to FBI or get what he wants including meds (benzos, Benadryl, morphine.....)
- Best approach for demanding continued hospitalization until he is "fixed"

## Outcomes....

- Admission interventions from psychiatry team, bioethics, Psychiatry OT, pastoral care, SW in addition to primary care by the surgical team and consultants  
TPN
- Many meeting with legal department
- Medication management:
  - Zyprexa, Lexapro and remeron.
  - Geodon / abilify IM prn.
- Guardianship application

## Continued....

- 9 months admission
- Exploratory laparotomy, lysis of adhesions, evacuation of intraperitoneal clot, and push enteroscopy beyond the duodenum into the jejunum, small bowel resection with side-to-side stapled anastomosis, and abdominal wall reconstruction with Permacol mesh.
- Discharged AMA shortly after surgery
- Readmitted with opioid WD within 2 days of discharge
- Readmitted to OSH hospital within one after discharge with FBI. Transfer was requested...

# Literature Review

# Literature Review: Foreign Body Ingestion

- Focus of review: FBI (rather than all self-injurious behavior).
- Comprehensive self-injury review: too broad for focused workshop.
- Delineated FBI literature into three categories of focus: GI, Epidemiology, Psychiatry.



# GI

- James and Allen-Mersh (1982)
- Case series, n= 5
  - 3 personality disorder, 1 pica, 1 malingering
- Review
  - Most impaction at cricopharyngeal sphincter: 78% out of 609 (Matheson, 1949).
  - Clear passage in 90% cases, only 0.5% complications: 1495 FBI cases (Schleifer et al, 1980).
- Management
  - Rec: conservative approach

# GI

- Soong et al (1990)
- Case report, n = 1 (6 year period).
- 250 Xrays, 170 days gen hosp bed days, 2 abd surgeries, 5 endoscopies, 60 occasions FBI/SIB.
- Few complications: peritonitis (fork), PNA (needles).
- Review: endoscopic removal above cricopharyngeal sphincter (Selivanov et al, 1984; Henderson et al, 1987; Grekin and Musselman, 1952).
- Management:
  - Rec conservative; surgery may increase risk for future perf.
  - Psych intervention does not prevent recurrence.

## GI

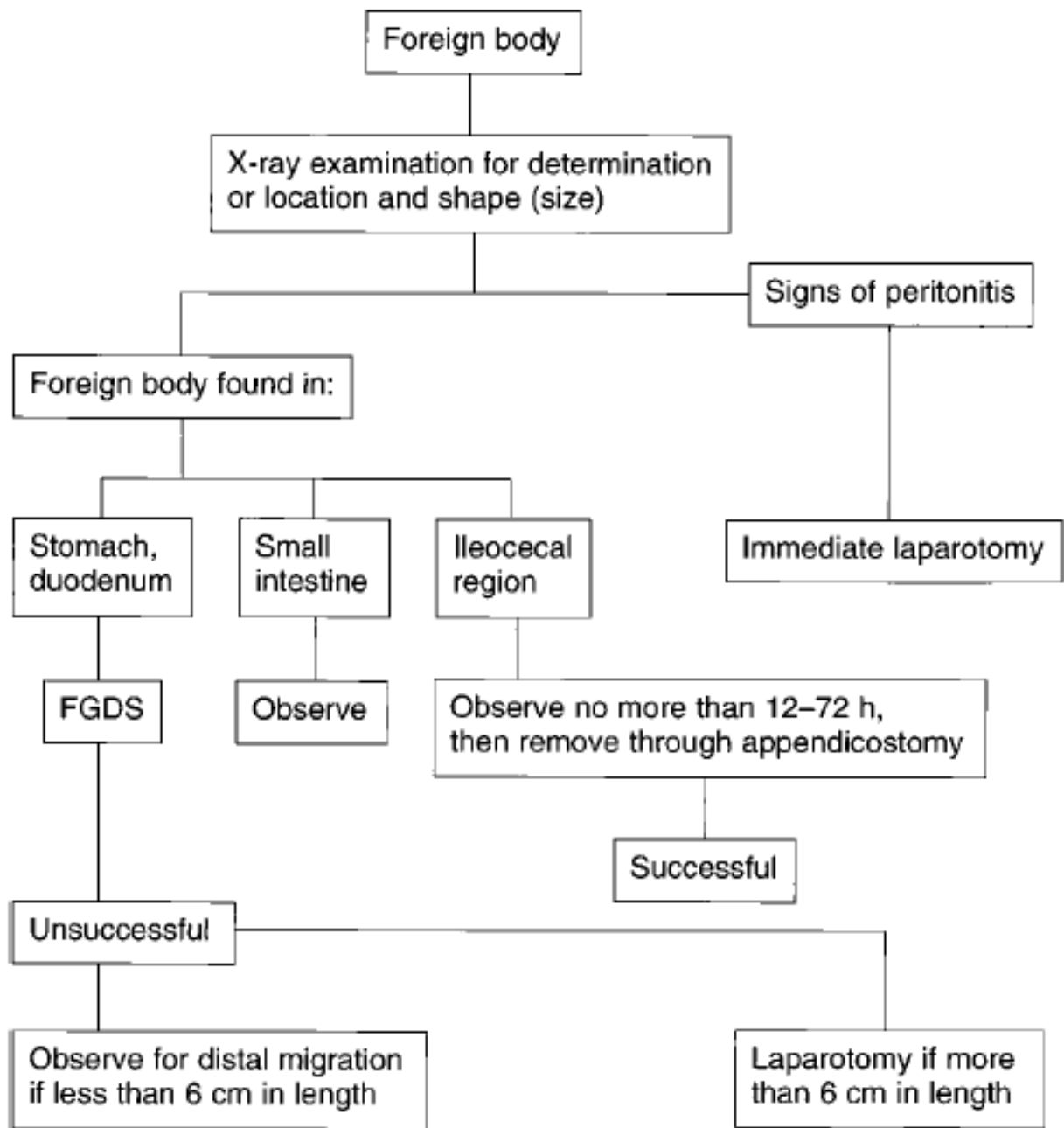
- Velitchkov et al (1996)
- Retrospective analysis (20 years), n = 542 (1203 total FBI).
  - Spoon handles (22), screws/nuts (320), paperclips (14), safety pins (64), razor blades (16), misc small objects (56).
  - 69.9% (n = 379) from jail
  - 22.9% (n = 124) psychotic
  - 75.6% (n = 410) passed spontaneously
  - 4.8% (n = 26) required surgery

## GI continued

- 30.8% (n = 8): long gastric FBs (could not pass, req gastrotomy)
- 15.4% (n = 4): thin/sharp FBs → perf
- 53.8% (n = 14): ileocecal impaction (appendicostomy)

- Management: Algorithm

GI  
• Velitchkov  
et al, 1996



# GI

- Blaho et al, 1998
- Case series, n = 8 (14 total FBI)
- ED setting, all male prisoners.
- All but one FBI: return to jail after ~5hr in ED
  - Single admission: observation post razor ingestion, pt tried to kill self in hospital by hanging (31 days).
- Management
  - Rec: conservative.

# GI

- Frei-Lanter et al, 2012
- Survey, n = 63
  - GI (23), psych (21), surgeons (13); Europe.
- Scenarios
  - Endoscopy for sharp FBs: 96% agreed.
  - Endoscopy for subsequent FBI: 86% agreed.
  - Psychiatry needed before endoscopy: 50% GI/surg.
    - 85% psychiatrists felt they should be called before EGD.
  - Know at least one BPD repeated FBI: 68%.
  - Know of cases where endoscopy not done: 21%.

# GI

- Frei-Lanter et al, 2012
- “It is not necessarily unethical to decide against repeated endoscopies. For these difficult-to-treat patients with BPD, an interdisciplinary (and ideally interinstitutional) consensus on the management of repeated FB ingestion is needed to optimize treatment and save costs and resources. This needs to be done for each BPD patient individually.”



# Literature Review -- Epidemiology

- Olson, Marcus, and Bridge (2013)
- Retrospective analysis of Medicaid patients (30 days post-ER discharge), n = 5567 self-harm events.
- Examined repeat self-harm in the ER.
- Variations in ER psych services available.
- Hypothesis: mental disorder recognition in the ER would be associated with a lower short-term risk of repeat self-harm visits and psychiatric hospital admission:
- “Initiate a chain of events that results in the delivery of effective mental health care and reduction of short-term risks.”

## Epidemiology – Olfson et al

- Multivariate analysis: estimate the effect of mental disorder recognition in the ER on the likelihood of repeat self-harm visit among patients who had recently been dx with various mental disorders -- inversely related: lower short-term risk of repeat self-harm.
- Recent dx of mental health disorder and self-harm was associated with increased risk of subsequent inpatient psych admit.
- BPD: highest risk group for repeat, deliberate self-harm.

## Epidemiology: Appelbaum et al

- Appelbaum et al (2011)
- Survey, n = 39 (77% of 51 surveyed).
- 30-item online questionnaire.
- State and federal prisons.
- Examined self-injury behavior in prison: prevalence, management.

## Epidemiology: Appelbaum et al contd.

- 0.71% of inmates engaged in SIB.
- After SIB: medical tx outside of prison facility after self injury: either 5% of the time or 5-10% of the time only.
- Moderately or extremely consumptive of services.
- Cluster B Personality DO most prevalent.
- Medications used only to treat underlying psych do.
- Many systems used restraints: security, mental health.
- Use of individual behavioral management plans varied.

## Epidemiology: Sullivan et al

- Sullivan et al (1996)
- Retrospective analysis (1989-1992), n = 36.
- 36 cases of deliberate fbi: 30 were institutionalized – 20 prison inmates, 10 psych hospital inpatients.
- Majority swallowed single objects.
- Batteries, glass, nails, razor blades, pins.
- Common: violence, impulsive, suicide attempts.
- Advise conservative treatment: majority will pass spontaneously without problems.

# Literature Review: Psychiatry

- Gitlin et al (2007)
- Literature review, case reports.
- Focus: little discussion in literature re: fbi.
- Uniqueness: nearly impossible to prevent access to all potentially ingestible objects.
- 4 Categories: malingering, psychosis, pica, personality do.

## Psychiatry: Gitlin et al

- Malingering: e.g. jail inmates and “gi crosses.”
- Psychosis: fbi due to delusions.
- PICA: associated with MR and Autism.
- Personality DO: provocative, “held hostage.”
  
- Most reports in surgery and GI literature.
- Support for DBT, supportive therapy, CBT, Naltrexone, Clonidine.
- FBI: more resistant to intervention, worse prognosis.

# Psychiatry

- Comtois, K (2002)
- Literature review (1970-2001).
- Addressed “parasuicide” (nonfatal, self-injurious behavior with a clear intent to cause bodily harm).
- Prevalence: 4.6% National Comorbidity Study.
- Parasuicide: established risk for eventual suicide.
- Standard of care (inpatient psych) for comorbid disorders (e.g. depression) may “inadvertently increase the problem they are designed to treat.”



## Comtois contd.

- Highlighted 5 treatments – reduced rate of parasuicide repetition: DBT, CBT, Home visits to assess noncompliance, antipsychotic (UK only), and psychodynamic interpersonal tx.
- “Usual care for parasuicide has not been studied.”
- Finland study (Suominen et al ) – little to no change in the quantity and frequency of care provided after parasuicide.

# Psychiatry

- Villalba et al (2000)
- Literature review
- Discussion of SIB variants:
- Repetition emphasis: compulsive, counter-dissociative, automatic, pain-induced.
- Meaning emphasis: psychotic, emblematic, parasuicidal.
- Opioid involvement, Serotonin 5-HT.

## Villalba et al contd.

- Pharmacological agents for rSIB: limited controlled trials, more open-labeled studies.
- Mixed results: Serotonin, atypical antipsychotics, naltrexone.
- Decrease in anger, aggression with rx.

# Psychiatry: Hoisholt AW

- Hoisholt AW (1917)
- Presentation at the American Medico-Psychological Association in NY.
- Case reports.
- Case report #1: state hospital patient, swallowed 921 objects: pins, safety pins, nails.
- Case report #2: 23 pieces of glass in the bowel.
- Case report #3: spoon, 6 missing links of bed springs.
- Case report #4: two teaspoons, perforated ileum.

**Health care providers and  
patients with self-injurious  
behavior (SIB):  
CCF Online Survey**

## Brief Background

- Hundreds of thousands of patients present to emergency departments for the treatment of SIB.
- Practice guidelines regarding the management of SIB are lacking.
- Disposition for patients with SIB is highly variable.

## Purpose of this survey:

1. To explore the knowledge, attitudes, beliefs, and practices held by health care providers regarding SIB.
2. To appreciate the impact of patients with SIB on these health care providers' practice, operation, and resources.

## Audience

- Physicians: internal medicine, surgery, GI, ICU
- Nurses: internal medicine, surgery, GI, ICU
- NP / PA
- SW / CM
- Hospitals: CCHS



## Questions

- Multiple choices with option to comment.
- Focus on the following areas:
  - General questions: provider practice, years of experience, specialty.
  - Patient diagnosis: recognition of possible underlying mental illness Axis I vs Axis II.
  - Management of those patients.
  - Role of mental health providers.
  - Disposition for those patients.

# Results and Discussion

## Survey Data

	Receivers	Respondents
MD/DO	121	23 (19%)
RN	318	51 (16.03%)
SW/CM	15	0 (0%)
Total	454	75 (16.51%)

# Survey Data

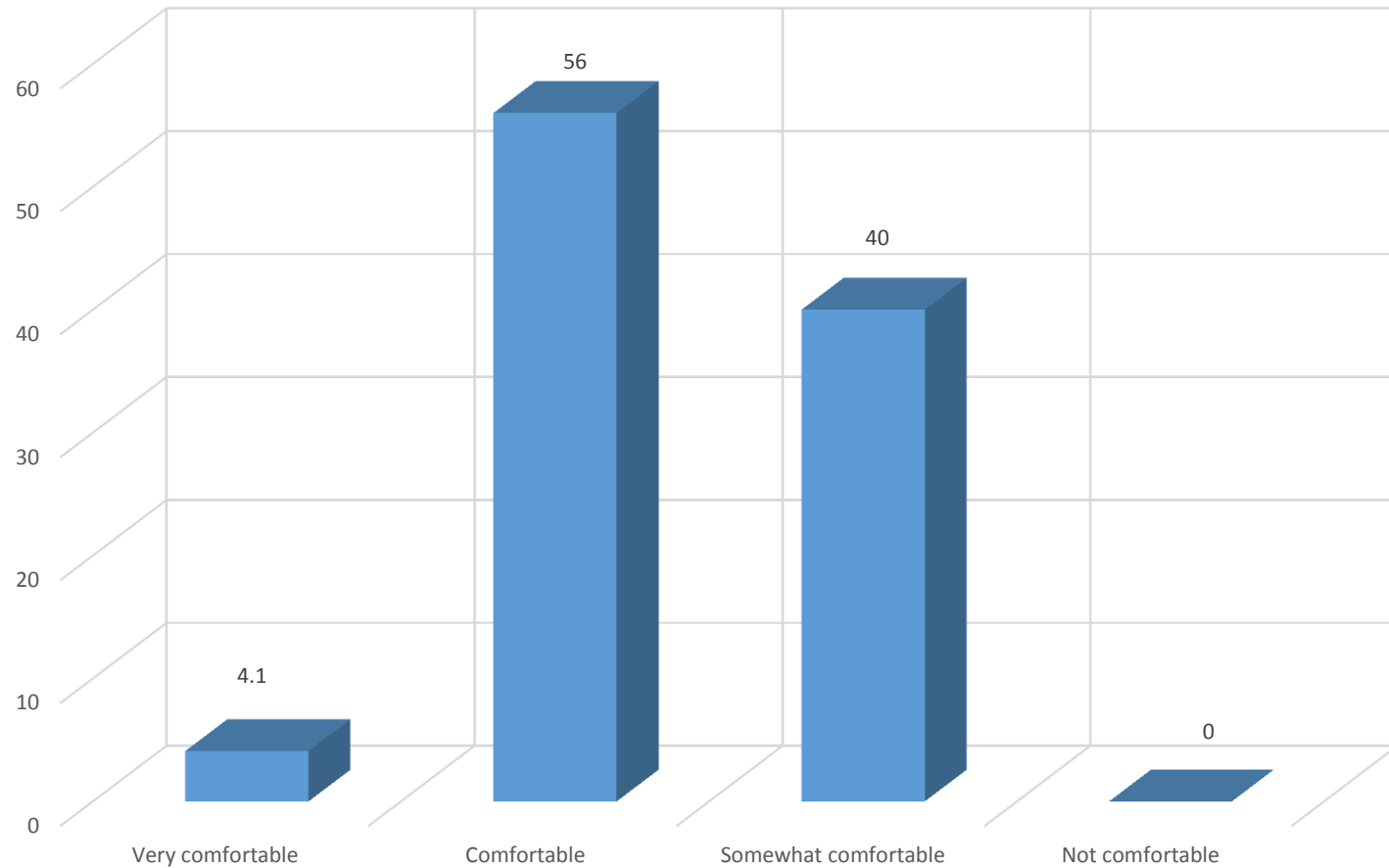
## Specialty:

- Internal Med: 72.3% (n=47)
- Surgery: 15.3% (n=10)
- Intensive/Critical Care: 3% (n=2)
- Gastroenterology: 9.2% (n=6)

## Years of Clinical Experience:

- Less than 5 years: 23
- 5-10 years: 18
- 10-20 years: 10
- Over 20 years: 11
- Range: 0-35

# Level of Comfort with Management of SIB



# Major Challenges Faced (N=58)

- **SAFETY:**
  - Serious injury to self
  - Personal safety among potentially violent patients is my main concern.
  - Monitoring the patient and preventing further injury
- **LEGAL/ETHICAL:**
  - Legal issues with restraints
  - Institutional coddling of these patients.
  - Resources used
- **MEDICATION:**
  - Behavior control - particularly use of psychotropics

# Challenges, Continued...

## UNCERTAINTY:

- I am unsure of how to care for this type of patient.
- You don't know what they are thinking
- How to control them
- **Equipment** in rooms and the ability for patients to roam. **Medical physicians** seem to not understand that the movement of the patients need to be restricted. They are manipulative and **the companions** do not seem to be properly trained for taking care of these individuals.

## Challenges, Continued...

- I do not know how to manage the behavior. They are very manipulative and we are not trained to manage the behavior. The only knowledge that I have gained from each case. **Psychiatry does not play a big role in their treatment.** I feel they see the patient for medication and that is it. They do not assist the staff in dealing with the behavior.
- How to approach them, talk to them, help them...
- Trying to break the cycle of re admissions for the same. Trying to tease out manipulative behavior from true intent to self injure.

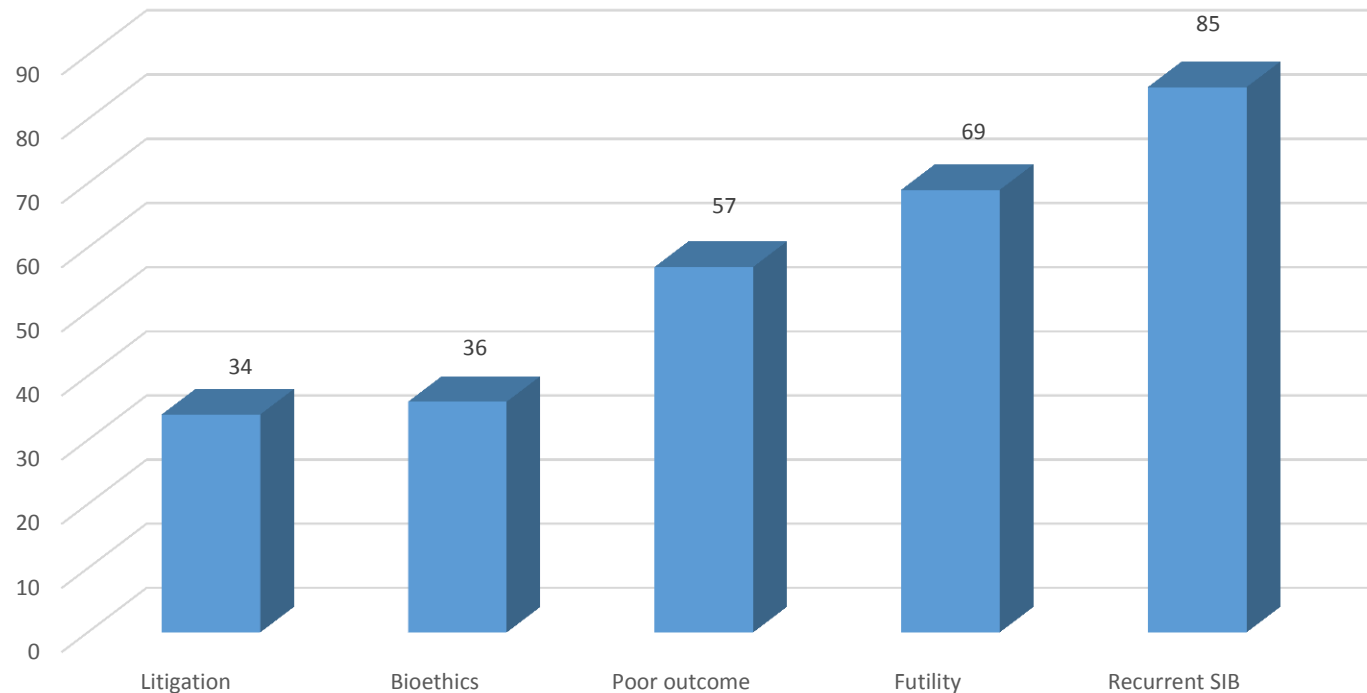


# Challenges, Continued....

## FRUSTRATION:

- 1) Communication with the patients and the patient family. 2) Disposition issues with regards to placement especially if the patient is uninsured. 3) Apathetic consultant staff and fellows- especially if the patient is stable but not ready to go home. They just linger on the medicine service for ever for ex; Just to get the FB moving and there is no plan of care from the consultants and no end date for discharge in sight.
- They do not change their behavior sometimes no matter what treatment, including psychiatric, is given which is frustrating
- Having a large patient load due to short staffing. These patients require a lot of time even though they have a sitter.
- Patient usually has a sitter. Taking the time to educate the patient on their actions. With a full patient load, sometimes these patients need the RN available to just sit and talk to them.
- Splitting care givers and plan of care, manipulative, pain seeking, disruptive (frequent CIT's), harm to self by disrupting care i.e. licking PICC or central line, self injection with PO meds given here or meds brought from home, using stuff in closet to manipulate/ harm self .

# Concerns in caring for patients with SIB



- Comments:
  - Safety in general
  - Them harming the caregivers
  - Lack of expertise.

# Opinion regarding Med/Surg management of FBI

- 6) Intervention is not needed as perforation risk is low: 4.6% (n=3)
- Intervention is only appropriate in cases of repeat swallowing: 4.6% (n=3)
- Should always intervene due to medical concerns: 60% (n=39)
- Should always intervene due to bioethical concerns: 9.2% (n=6)
- Should always intervene due to litigation concerns: 0

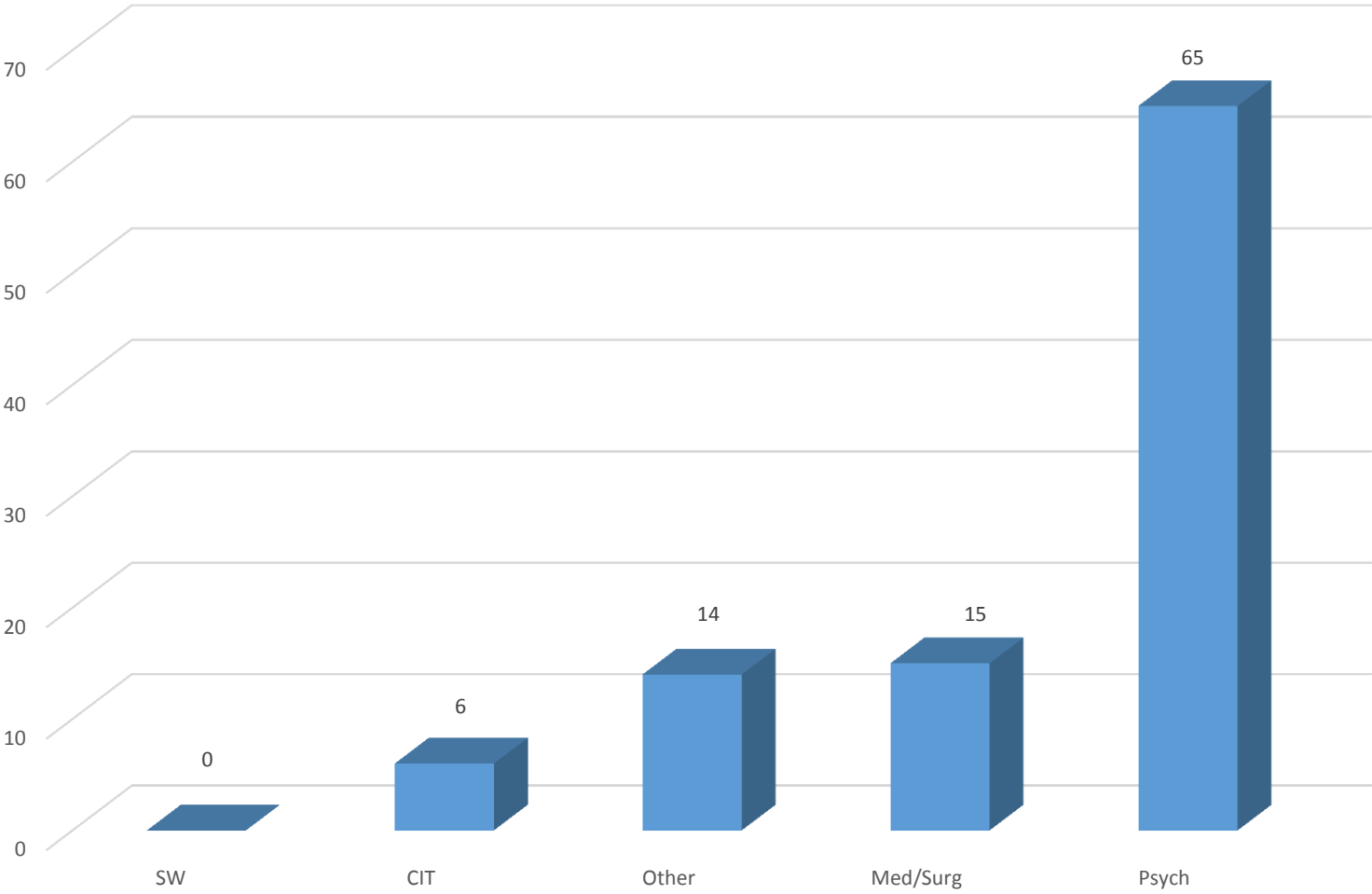
# Opinion regarding Med/Surg management of FBI, Comments (n=14)

- Intervene both ethical and medical reasons
- Intervention needs to be determined on an as needed basis depending on clinical relevance.
- I feel there needs to be a med psych floor with the proper set up for these patients.
- The risk of complications dictates the need to intervene
- Whenever patient seems our help or is brought to us we should intervene
- Should always intervene if the swallowed object has a risk of perforation or obstruction. Small objects that can pass and are not toxic can be left alone and follow with X ray

## Continued

- We should intervene on a case by case basis based upon risk of injury.
- These patients need to be monitored closely and need much education.
- We should intervene if clinically indicated.
- Intervention is appropriate in case of non-mobility of ingested objects.
- Intervention should be based on clinical judgment (presentation, imaging, type of object ingested).
- The intervention depends on the history.
- if you swallowed something more than twice, either you pay cash to get it out via EGD etc or deal with it on your own.

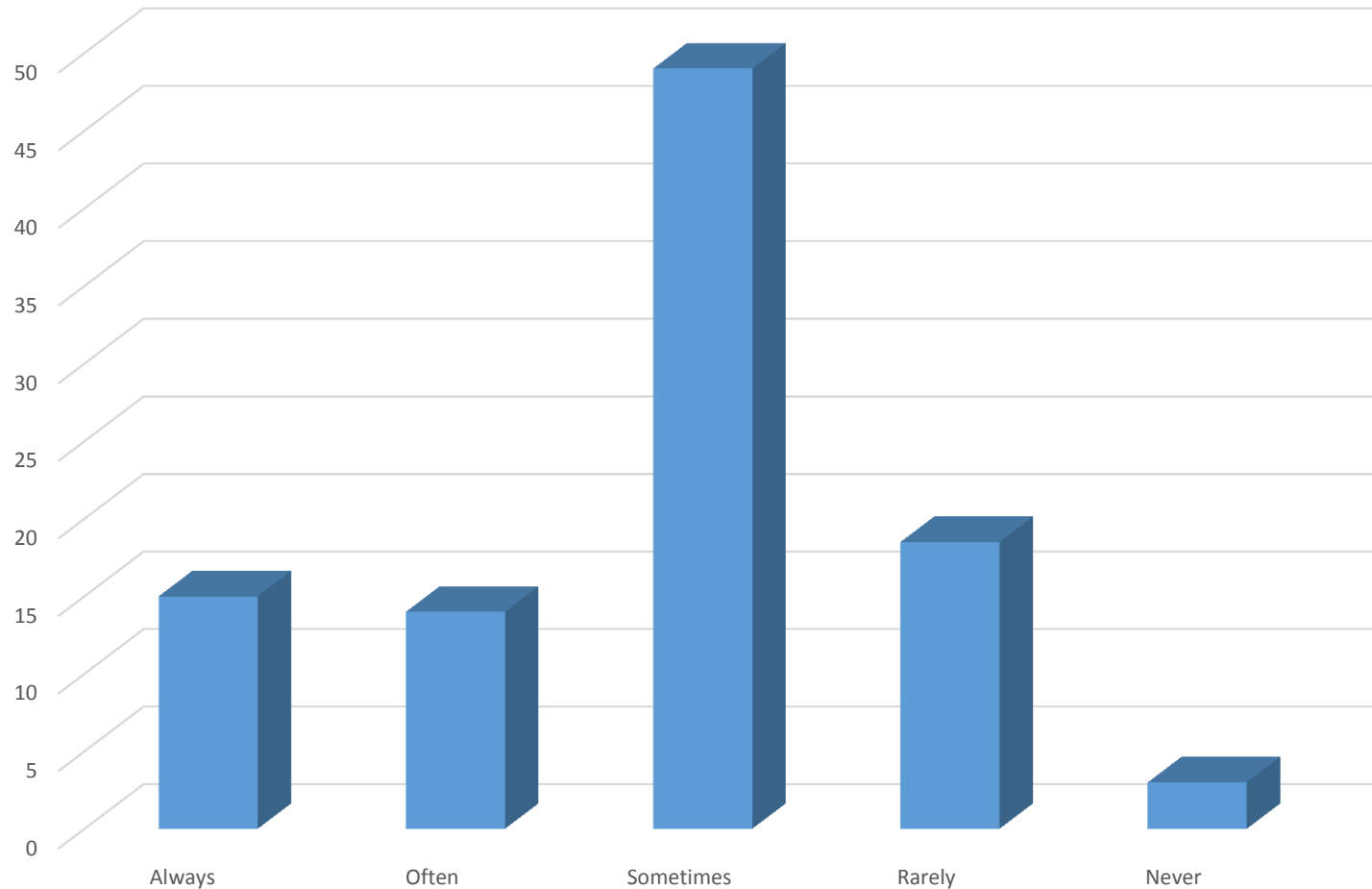
# Who should manage SIB?



# Who should manage SIB?

- Depends on how severe the behavior was - either Psych or Med/surg.
- Gastroenterology.
- The psychiatrist should be in charge - but in the immediate phases, they should be co-managed.
- Med/surg likely depending on primary reason for hospitalization, but psych should always be on consult.
- Multidisciplinary.
- All.
- These patients need help from everyone to reinforce positive actions and to educate them.
- Not sure.
- Depends - may be a case by case basis between psychiatry and medical/surgical team.

# How often are psych interventions helpful?





# What dispositions are you comfortable with (all that apply)?

- Hospital admission: 52% (n=34)
- **Psychiatric admission: 82% (n=53)**
- Home with PCP follow-up: 11% (n=7)
- Home with psychiatry follow-up: 28% (n=18)
- Home with community assertive team: 51% (n=33)

# What is SIB Prognosis?

- Acute episode, resolves spontaneously: 0
- Chronic condition with recurrence that improves with time: 3% (n=2)
- Chronic condition with recurrence that worsens with time: 13% (n=8)
- **Chronic condition with recurrence that may fluctuate over time: 72% (n=46)**
- Curable condition: 3% (n=2)
- Other: 9% (n=6)

# What is SIB Prognosis?

- Unknown.
- Not applicable.
- Most of these patients have difficult social support - the US health care system can not fix this.
- Not sure.
- Terminal, unlikely to improve.
- Depends on the severity of the psychological issues.  
Sometimes it is only done once and scares the patient.  
Other patients have chronic conditions with recurrent sib.

# Role Play

## Role Play: Goals

- Time to practice!
- To actively put into use skills discussed and learned during the workshop.
- To test what works (and maybe what does not) in a safe learning environment.

## Role Play: Scenario 1

- Consultation Psychiatrist and GI Staff:
  - You are the solo consultation psychiatrist for a large community hospital.
  - While in the midst of managing a combative patient, you are paged to speak with a GI staff member.
- The question: “Why have you not helped this patient yet?”

## Role Play: Scenario 2

- Consultation Psychiatrist and Bedside Nurse
  - You are the consultation psychiatrist for a large academic hospital.
  - Patient Ms. S is in the ICU again for FBI (non-suicidal) with sitter and suicide precautions, room stripped bare of all items.
  - The new ICU nurse (with little behavioral health experience) asks you a series of questions about taking care of the patient.

# CCF Checklist



# Considerations Checklist – Essential

- Safety
  - Of patient, providers, other patients
- Security
  - What do they need to do their job? Paperwork?
- Restraints
  - If so, to what extent?
  - Education of nursing/medical teams on use/indication
- 1:1 Companion (“sitter”)
  - Sitter education?
  - Sitter logs/notes?

# Considerations Checklist – Essential

- Psychiatric Consultation:
  - Full consultation for new?
  - Curbside for recurrent?
  - Co-morbid diagnosis?
- Disposition determination?
- Assistance with security/safety considerations (above)?
- Social Work/Case Manager Consultation
  - Additional psychosocial considerations?
  - Assist in Disposition?

# Considerations Checklist – Essential

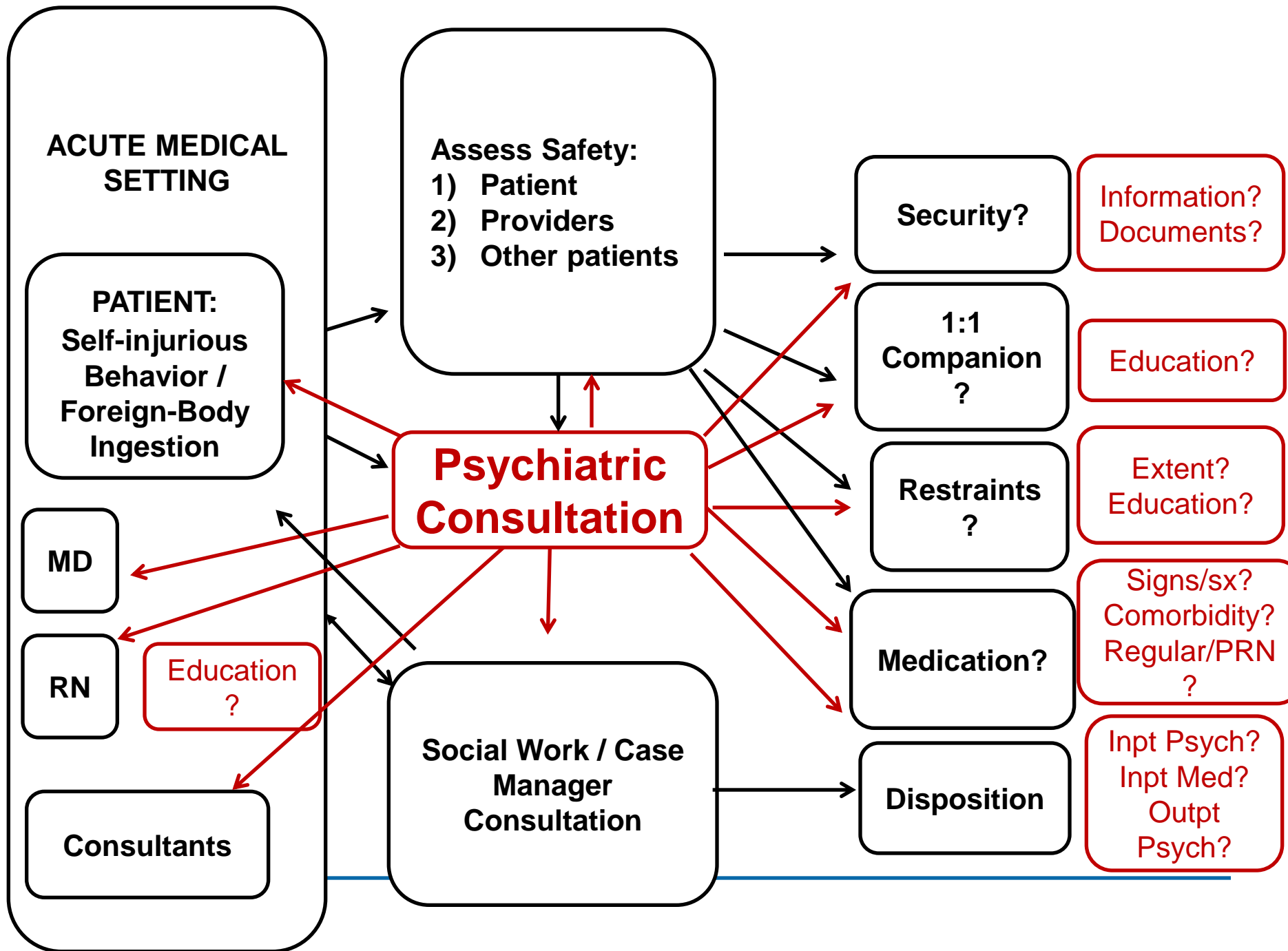
- Treatment
  - Impulsive behaviors?
  - Co-morbid anxiety, depression, psychosis, etc?
  - Standing vs PRN?
- Disposition
  - Inpatient medical
  - Inpatient psychiatric
  - Outpatient psychiatric

# Considerations Checklist – Adjunct

- Nursing Education
  - Limiting personnel interacting with patient
  - Normalizing frustration/anxiety
  - Explanation of severe pathology (“less than 1%”)
  - United front; minimization of splitting
  - Restraints education (“floor is temporarily psych unit”)

# Considerations Checklist – Adjunct

- Legal/Ethical Issues
  - Consultants?
  - Foreign Body Ingestion (FBI)
  - Removal vs Conservative Management?
- GI/Surgery consultation?
  - Ongoing Plan of Care
  - For recurrent patients/problem?
- Gather all stakeholders?
- EMR considerations?
- Risk Mgmt/Legal, Ombudsman, Ethics involvement?



## Summary

- Patients with Foreign Body Ingestion remain one of the most challenging populations to care for.
- Certain patients are resistant to improvement despite our best efforts.
- Focus on: safety – maintenance of safety while in the hospital, as well as coordination of care with outpatient providers.
- Documentation of all efforts being made to aide the patient is key.
- Provide collegial support for colleagues, and stay patient and calm during trying times.

# References

- Blaho KE, Merigian KS, Winbery SL, Park LJ, Cockrell M. Foreign body ingestions in the emergency department: case reports and review of treatment. *The Journal of Emergency Medicine*. 1998; 16(1):21-26.
- Comtois KA. A review of interventions to reduce the prevalence of parasuicide. *Psychiatric Services*. 2002; 53(9):1138-1144.
- Frei-Lanter CM, Vavricka SR, Kruger THC, Tutian R, Geier A, Bauerfeind P, Krones T, Fried M, Frei P. Endoscopy for repeatedly ingested sharp foreign bodies in patients with borderline personality disorder: an international survey. *European Journal of Gastroenterology and Hepatology*. 2012; 24:793-797.
- Gitlin DF, Caplan JP, Rogers MP, Avni-Barron O, Braun I, Barsky AJ. Foreign-body ingestion in patients with personality disorders. *Psychosomatics*. 2007; 48(2):162-166.
- Hoisholt AW. Impulsive acts in the particular form of swallowing foreign objects, as met with among the insane. Meeting of the American Medico-Psychological Association. 1917; 569-580.
- James AH and Allen-Mersh TG. Recognition and management of patients who repeatedly swallow foreign bodies. *Journal of the Royal Society of Medicine*. 1982;75:107-110.
- Soong CV, Harvey C, Doherty M. Self-mutilating behavior and deliberate ingestion of foreign bodies. *The Ulster Medical Journal*. 1990; 59(2):213-216.
- Velitchkov NG, Grigorov GI, Losanoff JE, Kjossev KT. Ingested Foreign Bodies of the Gastrointestinal Tract: Retrospective Analysis of 542 Cases. *World Journal of Surgery*. 1996; 20:1001-1005.
- Villalba R, Harrington CJ. Repetitive self-injurious behavior: a neuropsychiatric perspective and review of pharmacologic treatments. *Seminars in Clinical Neuropsychiatry*. 2000; 5(4):215-226.



Thank you!

# Questions