Care plan for patients who swallow foreign bodies

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Introduction: Care of patients who swallow foreign bodies requires effective communication and shared management amongst emergency room, gastroenterology, psychiatric, and general surgical staff. The purpose of this document is to provide a template for the management of such patients, in order to streamline their care, ease communication amongst team members, and manage resources as effectively as possible. It is understood that these principles will be tailored to fit a particular individual, as required by clinical judgment.

Emergency room:

- Swallowing behaviour is not specifically suicidal and in and of itself is not evidence to place someone on a Form 1.
- The patient should be approached with courtesy and compassion as per any patient, but limits should also be set and communicated; the patient should be informed that we will try to help them but they MUST not swallow objects in the ER and must cooperate with their care or they may be asked to leave.
- We should generally consider the patient competent to refuse care. IF they refuse care, they should be discharged (write a good note!)
- If they agree to be scoped for object removal, consult GI. Only consult Gen Surg if there is evidence of or concern for a perforation.
- If GI advises removal by scope and patient agrees, in general, do it as quickly as possible and discharge them. This may mean scoping in the ER under conscious sedation. Please facilitate this any way we can. If volume permits the ER doc to assist with sedation, that's fine, otherwise call anesthesia for assistance.
- If patient requires admission, Medicine should admit with GI consulting as this situation does not meet the criteria for GI admission.
- Patients generally do not require psych consultation every presentation. IF they disclose a personal crisis or acute emotional issues that would benefit from consultation that is fine, but psych. assessment - especially if it leads to a delay in enacting this plan - is not necessary on every visit. Call them if you need then, however.
- These patients frequently have psych f/u in place somewhere. Encourage the patient to return there on discharge.
- Avoid a power struggle. Patients should NOT end up formed and restrained in most circumstances.
- These patients can often swallow in hospital, especially post-endoscopy. Even if not formed, we can request constant observation. The guard should be instructed to remove all dangerous objects that could be swallowed from their vicinity; their room, clothing, personal belongings and immediate vicinity. Watch for batteries, utensils (even plastic), medical devices such as cannulas and needles, pens are all a risk. Coins are not much risk (see GI section below for details). If patient is not on a Form the guard should not
prevent them from leaving, but they should be escorted out to ensure no further swallowing happens within the hospital. Patients should be warned that they will be discharged if they try to swallow and then we should follow through. If patient is discharged and returns having swallowed again, just repeat the entire process.

Psychiatry:

Presentation: Typically such patients are young women with a long established practice of swallowing a variety of objects such as razor blades, pens or needles. They typically present with a flat affect, and will describe their actions but not elaborate on precipitants or history. They may be well known to staff from multiple presentations in the past. It is frequently the case that the swallowing behavior occurs in ‘runs’, such that they may present repeatedly to the same (or a variety) of ER’s in a short period of time. Characteristic of this patient population is the degree of frustration and powerlessness created in the treating staff.

Diagnosis: The psychiatric differential diagnosis includes psychotic behavior, pica, antisocial personality, and factitious disorder. However by far the commonest diagnosis assigned to these patients is borderline personality disorder, often as a consequence of significant prolonged childhood trauma (1). The swallowing is best understood as a variation on chronic self-harming behavior such as cutting or para-suicidal overdoses. If an alliance is established with the patient it is often the case that a fairly straightforward precipitant has occurred, such as losing housing or a rejection in an important relationship. The swallowing is understood as an impulsive and maladaptive attempt at emotional regulation. However, it is characteristic of these patients that a therapeutic alliance is difficult to establish under calm circumstances, and often essentially unavailable in the pressurized emergency treatment situation.

Staff reactions: Staff will find it helpful in managing their own reactions to these patients to keep in mind the extent of their past trauma, current difficulties, and severe impairment in managing basic human interactions. The ‘invitation’ from the patient’s presentation is to enter into a power struggle, with the physician working hard to control the behavior of the patient, and inevitably being defeated by them. This can evoke tremendous frustration in treating staff, which in turn can precipitate dismissiveness or over-control. However, our job is to ensure safety as a consequence of the swallowing that has occurred, and prevent further swallowing whilst the patient is in the care of the institution. We cannot regulate the patient's behavior in the community, even a few steps outside the door. Refusing the invitation to participate in a power struggle by not assuming responsibility for their swallowing behavior is a more useful stance which does not challenge the patient to prove they have more power than we do. It may also create a space in which some therapeutic alliance occurs, as the patient understands that despite their testing of staff they are being treated as adults. Occasionally in these circumstances the patient demonstrates higher abilities and capacity than one would have anticipated from her initial presentation, and can participate in solving the here-and-now issue that is most troublesome.

Management: Most such patients have identified therapists or treatment teams that are their primary supports, even if they only attend sporadically. Ultimately the treatment for this behavior depends on the establishment of a trusted relationship with this specific treatment team.
Therefore, whenever possible management should be as brief as is consistent with medically appropriate care and the patient should then be directed back to their team. This consistent message diminishes fragmentation of care.

Psychiatric consultation in the emergency room is recommended in order to determine diagnosis and disposition and to address whether or not certification is required. Typically such patients are not placed under a Form (i.e. restricted from leaving) and are understood to be competent to make treatment decisions, even when they remain at high risk for repeating the self-harming behavior. Where the patient requires admission on the basis of medical or surgical grounds, the consultation-liaison psychiatric team should be immediately involved, to help manage behavior on the ward and organize effective discharge. Psychiatric inpatient admission is rarely used and should be reserved for those times when a clear therapeutic contract can be established between the patient and the inpatient service which specifically addresses the goals of treatment, and delineates the consequences of further swallowing on the ward, which should include discharge from the service as soon as is medically appropriate. The patient should be provided with a copy of her contract. Absence of such a contract will typically permit accelerated regression and further swallowing or self-harm.

Utilization of therapies shown to be helpful for self-harm, such as dialectic behavior therapy, show some promise in helping this population. However these teams are not available on an urgent basis.

Psychiatric summary:
1. Swallowing foreign objects occurs as a consequence of impulsive maladaptive emotional regulation at a time of high stress.
2. There is no established specific pharmacological or psychotherapeutic intervention for this population.
3. Patient management should be guided by the principle of the minimum intervention that is compatible with safe clinical management, control of the environment to reduce opportunities for further swallowing, and diminution of fragmentation of care.
4. Notwithstanding the obvious maladaptive nature of this behavior, patients are most frequently competent to make treatment decisions in that they understand and appreciate what they have done, and what the consequences of treatment or non-treatment will be.
5. Patients should be understood to have a reason, albeit often obscure or apparently insufficient for this behavior. Appreciating this can help in not engaging in a power struggle, which may in turn diminish an escalation of behavior.

Gastroenterology:
1. This documentation serves as general guiding principles regarding management of foreign objects ingested in the GI tract. However, the treating physician is required to use his/her clinical judgment on a case-to-case basis that may deviate from the following suggested recommendations. Details can be referred to the ASCE guideline (2).
2. In general, **urgent endoscopic intervention is required** when:
   i. A disc battery or sharp objects are lodged in the esophagus
   ii. Ingested foreign object causes high grade obstruction such that the patient is unable to manage his/her saliva.
   iii. Under no circumstances, should foreign objects remain in the esophagus beyond 24 hour from presentation.

3. **General anesthesia is usually not required.** However, the endoscopist needs to take into account the patient’s ability to co-operate, the number and type of objects to be retrieved or removing a foreign object that has likely been lodged in the esophagus for a prolonged, or unknown, duration period of time.

4. **Blunt objects** (e.g. coins):
   i. If lodged in the esophagus, need to be removed (2, iii)
   ii. If in stomach, most will pass in 4-6 days, but may take up to 4 weeks. If patient is asymptomatic, continue regular diet, and weekly radiography is adequate. However, round objects > 2.5 cm in diameter are less likely to pass the pylorus; hence, if it fails to leave the stomach in 3-4 weeks, it should be removed endoscopically.
   iii. Once it passes the stomach, surgical removal is required if object remains the same location for > 1 week.

5. **Long objects** (e.g. pens, spoons or toothbrush):
   i. Objects longer than 6-10 cm will have difficulty passing the duodenal sweep and should be removed with the appropriate techniques. A longer (>45 cm) overtube that extends beyond the GEJ is beneficial.

6. **Sharp-pointed objects** (e.g. paperclips, toothpicks, needles, bread bag clips and dental bridigework)
   i. One must define the location of the object urgently
   ii. If lodged in the esophagus, it is a medical emergency
      a. if above the cricopharyngeus, consult ENT for direct laryngoscopy
      b. if in esophagus, urgent endoscopy is required
      c. Once the object enters the stomach, the majority will pass. However, the estimated complication rate is ~ 35%. If the object is reachable by an endoscope, it should be removed with a long overtube.
      d. If it passes beyond the proximal duodenum, follow it with daily abdominal X-ray until passage occurs. Consider surgical intervention if it fails to progress for 3 consecutive days; intervene sooner if the patient becomes symptomatic.

7. **Disc batteries**
   i. If in esophagus, see 2
   ii. If in stomach, most disc batteries are passed without consequences. Batteries > 2 cm in diameter which do not pass beyond the stomach in 48 hr require endoscopic removal.
   iii. Once entering the duodenum, 85% pass within 72 hours. Abdominal X-ray every 3-4 days is recommended.
8. **Call Poison Control** if you have concerns or questions regarding the need of urgent removal of ingested foreign body (Toronto region: 416 813 5900 or toll free number: 1-800-268-9017)

**Bioethics:**
The ethical issues in providing care for these patients include:
1. the requirement to fulfill our duty to care which extends to all patients. It is important that our approach incorporates recognition of the vulnerability of those with psychiatric issues that influence behaviours.
2. the need to allow resource allocation decisions to be made at the level of policy rather than at the bedside

**References:**