

Case Report

Successful Expectant Management of Multiple Spoons Ingestion in a Psychiatric Patient. An Unusual Case Report

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Abstract

The management of foreign body ingestion is a clinical dilemma that is often encountered, and 80% of these cases do not require intervention as they will pass out spontaneously. We presented a case of multiple spoon ingestion in a 32-year-old psychiatric patient who had previous abdominal surgery for a similar problem. This case report attempted to elucidate the option and considerations in managing foreign body ingestion.

Keywords: Endoscopy; foreign body; paediatrics; psychiatry; spoons ingestion

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Introduction

The handling of foreign object ingestion poses a frequent clinical challenge, with approximately 80% of instances resolving without the need for intervention as they typically pass spontaneously. Predominantly, incidents of foreign object ingestion are observed in the paediatric age group. However, among adults, the at-risk population encompasses individuals with intellectual disabilities, psychiatric disorders, drug or alcohol intoxication, and those with a history of criminal activity (1). In this context, we described a case involving a 32-year-old psychiatric patient who ingested multiple spoons. The case was effectively addressed through endoscopic management and a non-operative approach.

Case Report

A 32-year-old lady was brought by her husband to the Emergency Department for suspected foreign body ingestion. It was suspected by her husband that a few spoons were missing after dinner.

Prior to this incident, the patient had a previous history

of foreign body ingestion two years ago. At that time, she ingested a sharp object namely a brooch that was dislodged in the small bowel. Due to the high risk of bowel perforation, the decision was made to perform a laparotomy and object retrieval. The surgery was deemed successful and she was discharged well. Unfortunately, she had another episode of foreign body ingestion which was successfully retrieved via endoscopic retrieval.

The patient was diagnosed with major depressive disorder for 20 years and was under Psychiatric follow-up. She had multiple episodes of alleged self-harm and suicidal attempts. She came from a lower-income family and had poor social support. She did not bear children and her husband was out to work most of the time.

Upon examination, she was clinically stable and there was no tenderness or signs of peritonism, which might indicate bowel perforation. A previously healed laparotomy scar was noted on her abdomen. Her blood parameters were also unremarkable. The plain abdominal radiograph showed three spoons dislodged in the stomach and another spoon in her transverse colon, as shown in Fig. 1.



FIGURE 1: The abdominal radiograph showed four spoons

The patient was resuscitated in the Emergency Room with intravenous crystalline fluid and antibiotics. An immediate diagnostic oesophago-gastroduodenoscopy (OGDS) procedure was performed with the intention of retrieving the spoons. Three of the spoons were successfully retrieved by using snare polypectomy forceps. There were no immediate complications.

The patient was treated expectantly for the other spoon, which remained in the transverse colon. She was closely observed in the surgery ward and was given laxatives to aid in the passing out of the spoon. Serial plain abdominal radiographs had to be performed to confirm the passage of the spoon. She was subsequently planned for sigmoidoscopy and removal of a foreign body on day 7 as the last spoon was seen in the rectum on the abdominal radiograph. Patient however denied any passing out of the spoon per anus. The patient was discharged well with no immediate complications.

Discussion

Psychiatric disorder is one of the risk factors of bizarre foreign body ingestion (1). Our patient with underlying psychiatric disorder had ingested four large spoons due to her impulsivity, which seemed to be triggered by social stressors. The clinical approach of foreign body ingestion depends upon the size, type of material, and the clinical condition of the patient (2).

Emergency endoscopy is warranted for ingested foreign bodies causing complete gastrointestinal (GI) obstruction, irregular objects with sharp and pointed edges, or chemically harmful foreign objects such as

batteries (3). Urgent endoscopy within 24 hours is generally indicated for large objects of more than 6cm long or 2.5 cm diameter in the stomach as it can cause absolute GI obstruction; specifically at the pylorus or ileocaecal valve. The patient was stable enough without airway obstruction and was not showing evidence of enteric perforation, as shown by Fig. 2, three spoons can be seen at the pyloric antrum of the stomach. The risk of gastrointestinal obstruction cannot be understated. Therefore, urgent retrieval had to be performed and after assessment, was feasible at that time. Three dislodged spoons were successfully retrieved using a snare device via the OGDS scope device, as shown in Fig. 3.

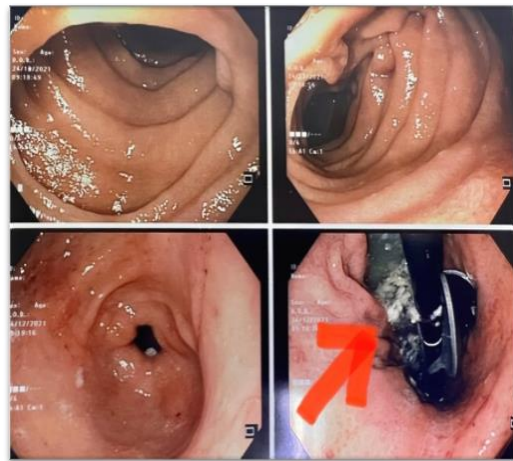


FIGURE 2: The red arrow indicated three spoons that were lodged in the stomach



FIGURE 3: Three spoons were successfully retrieved via endoscopy

Surgical exploration and removal of ingested foreign bodies via laparotomy is indicated in about 1% of cases only. This approach is preferred in clinically proven enteric perforation or complications that cannot be resolved endoscopically such as bleeding (4). This approach was not considered as the first option because the patient had previous surgery. Subsequent laparotomy will only increase the chance of injury to the bowel such as bowel tear or perforation. The risk of another laparotomy compared to its apparent benefit was much higher in this patient. That was why endoscopic retrieval was preferred.

Another approach to the management of foreign body ingestion is expectant management with close monitoring in the ward. We had chosen this path for the fourth spoon as it had passed beyond the pyloric sphincter. OGDS scope would not have adequate length to go beyond the duodenum. The abdominal radiograph seemed to indicate that the fourth spoon was in the transverse colon. This option was viable in stable adults with small blunt object ingestion or foreign body in the proximal colon and was found to be effective and safe (5). These patients should be observed closely for signs of enteric perforation through serial abdominal palpation supplemented with serial abdominal radiographs. A computed tomography scan of the abdomen would not add value in this case; therefore, it was not performed.

Airway assessment is pivotal in the initial management of foreign body ingestion. Endotracheal intubation is needed if the airway is compromised due to impaction in the upper oesophagus. Other considerations for intubation would include multiple foreign body ingestion with an unknown duration of ingestion (5). Oropharyngeal suction should be made available throughout the procedure to prevent aspiration of saliva into the lungs.

The forward-facing, flexible endoscope is preferable than the rigid endoscope. A double-channel endoscope can be more advantageous than the standard caliber endoscopes as it can help in the clearance of food particles better. However, an operator might find it difficult to navigate through the oesophagus and stomach using these rigid endoscopes. Moreover, there is a higher chance of perforations in rigid endoscopes compared to flexible scopes (6); therefore, the decision to choose lies on the experience of the endoscopists.

The usage of various endoscopic tools is subject to the types of foreign body ingested, availability, and preference of endoscopists. The tools frequently used are the rat-tooth forceps as well as polypectomy snares (7). Generally, coins are the best to be retrieved by

retrieval net, rat-tooth forceps, and polypectomy snare as they grab the object better. Round objects, such as button batteries are the best to be retrieved using retrieval net (8). In this case, the spoon was successfully retrieved using a polypectomy snare.

Conclusion

Endoscopic intervention and subsequent monitoring in managing foreign body ingestion remains a safe and viable option. The selection of patients with types of ingested material determines the choice of modality and subsequent outcome. Our case has clearly illustrated the safety and suitability of embarking on these two approaches.

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