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Online Only Clinical Record

Bulimia and oesophageal foreign bodies

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Abstract

Objectives: To demonstrate the importance of a detailed history when assessing patients with a repeated pattern of foreign body ingestion.

Case report: A 19-year-old woman presented to our department following accidental ingestion of a teaspoon. On further questioning, she admitted to a habit of binge-eating followed by self-induced vomiting, in order to avoid weight gain; she blamed this behaviour on a stressful relationship with her partner. She also had one previous episode of accidental ingestion of a plastic spoon, which had been removed by oesophagogastroduodenoscopy. The patient underwent an uneventful rigid oesophagoscopy and foreign body removal. During post-operative recovery, she admitted that she had suffered for years with bulimia and anorexia nervosa. She was discharged home after appropriate psychiatric counselling, and follow up was arranged.

Conclusions: Oesophageal foreign bodies are commonly encountered in otolaryngology practice. Such circumstances are often compounded by pre-existing psychiatric problems such as bulimia and/or anorexia nervosa. Patients with bulimia may often present with a very similar pattern of multiple episodes of ingestion of large foreign bodies. Identification of this eating disorder (especially when there is a recurrent history of large, accidentally ingested foreign bodies) and prompt psychiatric referral is essential for efficient long-term management of this condition.

Key words: Foreign Body; Oesophagus; Bulimia Nervosa

Introduction

Oesophageal foreign bodies are commonly encountered in otolaryngology practice. Such circumstances are often compounded by pre-existing psychiatric problems such as bulimia and/or anorexia nervosa. Patients with bulimia may often present with a very similar pattern of multiple episodes of ingestion of large foreign bodies. Identification of this eating disorder, especially when there is a recurrent history of large, accidentally ingested foreign bodies, and prompt psychiatric referral is essential for efficient long-term management of this condition. We present the case of a young woman who suffered for years with bulimia nervosa, leading to a pattern of repeated foreign body ingestion.

Case report

A 19-year-old woman presented to our department after accidentally swallowing a metallic teaspoon. On admission, she complained of throat and chest discomfort and dysphagia, but there was no airway compromise. On further questioning, she admitted to a habit of binge-eating followed by self-induced vomiting over the last few months, during stressful periods with her partner. She had had one previous episode of accidental ingestion of a plastic spoon, which had been removed by oesophagogastroduodenoscopy.

Examination of the oral cavity, including flexible nasendoscopy, was normal. Neck palpation was unremarkable, with no evidence of subcutaneous emphysema. The patient's body mass index was within normal limits. Chest X-ray showed a radiopaque body consistent with a teaspoon occupying the upper and middle third of the oesophagus, just below the cricopharyngeus (Figure 1). There was no evidence of any mediastinal air and the lung fields were clear.

The patient underwent an uneventful rigid oesophagoscopy to retrieve the teaspoon. During the immediate post-operative period, the patient complained of chest pain, but a Gastrografin swallow did not demonstrate any leak of the contrast through the oesophagus (Figure 2). The chest discomfort improved eventually following medical treatment with hyoscine butylbromide.

The patient was discharged home after further psychiatric counselling, and follow up was arranged.

Discussion

This patient accidentally ingested a large teaspoon, which was lodged in the upper and middle third of the oesophagus and necessitated removal by rigid oesophagoscopy. Ingestion of large and unusual foreign bodies has been described in paediatric and psychiatric patients. The management of large oesophageal foreign bodies involves rigid instrumentation in order to retrieve objects which may pose a hazard to the patient. Large foreign bodies with sharp edges can pose a risk of perforation as they transit through the gastrointestinal tract, and may necessitate laparotomy for retrieval. Thus, these patients place themselves at risk of undergoing unnecessary operative procedures, with all the potential associated morbidity and mortality risks.

Oesophageal foreign bodies are often encountered in otolaryngology practice. Russell first described bulimia

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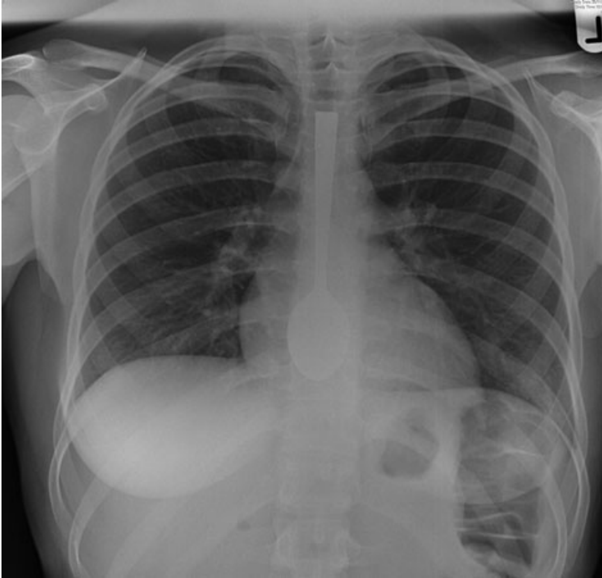

FIG. 1

Anteroposterior chest X-ray showing teaspoon in the oesophagus.

nervosa in 1979 in a case series of 30 patients.[1] The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* criteria for diagnosing bulimia nervosa include characteristic extreme concern about body shape and weight, recurrent episodes of an irresistible urge to over-eat, described as 'binge-eating', followed by extreme measures to control body weight.[1] Bulimia is most commonly described in women in their twenties, and can be classified as purging or non-purging. The purging type is characterised by self-induced vomiting, misuse of laxatives and enemas. The non-purging type is characterised by fasting and excessive exercise. The best assessment tool for bulimic features is the eating disorder examination.[2] Management of bulimia includes cognitive behavioural therapy, interpersonal psychotherapy and antidepressants.

Conclusion

It is important to identify any possible hidden psychiatric illness in patients encountered in otolaryngology practice. The diagnosis of bulimia nervosa is easily made when patients present with a recurrent history of large, accidentally ingested oesophageal foreign bodies. Identification of this eating disorder and prompt psychiatric referral are essential for efficient long-term management of the condition. Otherwise, patients will repeatedly present with foreign bodies in the digestive tract and succumb to repeated interventional procedures, with all the risks of potential complications. Management of these patients is inadequate without proper psychiatric input.

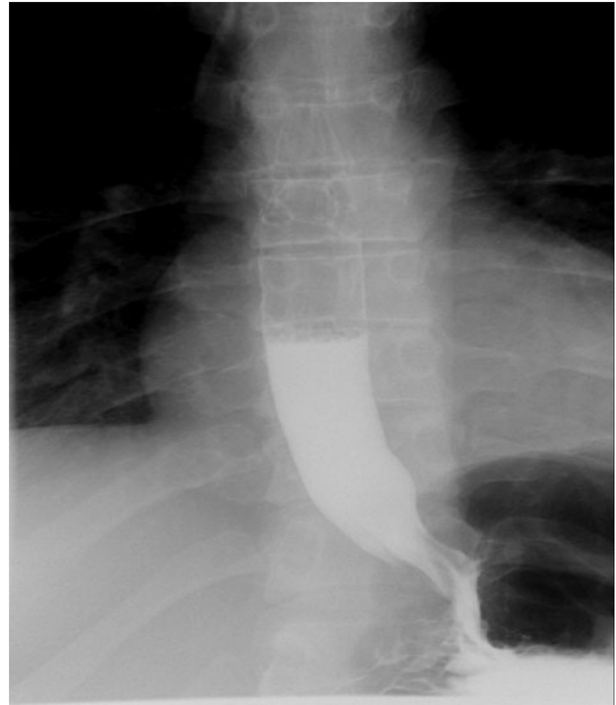

FIG. 2

Normal Gastrografin swallow.

References

1 Russell GF. Bulimia nervosa: an ominous sign of anorexia nervosa. *Psychol Med* 1979;**9**:429–48

2 Fairburn CG, Cooper Z, Doll HA, Norman P, O'Connor M. The natural course of bulimia nervosa and binge eating disorder in young women. *Arch Gen Psychiatry* 2000;**57**: 659–65

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