

Abdominal pain and melena in a delirious older patient: think out of the box

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CASE REPORT

A man, 81-years-old, was admitted to a geriatric ward with a pneumonia accompanied with a severe hypermotoric delirium. Halfway through his admission the nurses reported melena. The patient complained of abdominal pain, but because of his delirium and underlying dementia he was unable to provide details about the duration, severity and accompanying symptoms. The nurses had observed a poor appetite, but no vomiting or swallowing problems. The abdominal examination was normal. His medical history did not reveal dyspepsia or a bleeding diathesis. He was taking acetylsalicylic acid and mirtazepine together with omeprazole to counterbalance the slightly increased risk of bleeding of this combination of drugs. He had already been on this combination for years without problems. His blood counts beforehand were normal, with a 1.2 mmol/l drop in haemoglobin during the melena.

WHAT IS YOUR DIAGNOSIS?

See page 368 for the answer to this photo quiz.

Figure 1. Radiograph including an arrow pointing to the drawing pin



DIAGNOSIS

Ultimately a nurse reported that she had seen the patient investigating a cup of drawing pins on the drawing board. A plain abdominal radiograph showed a drawing pin in his intestines with no signs of perforation. It is likely that the pin had scratched the mucosa of the oesophagus and stomach. We had no other explanation for the melena. Furthermore, after omeprazole in a high dose of 40 mg twice daily for a few days and extra laxatives, the melena and abdominal pain resolved. The drawing pin was no longer present on a subsequent radiograph two weeks later. Because of the severe delirium, a gastroscopic evaluation had not been feasible to check for mucosal damage or other pathology. Although the pin is the likely cause of the melena, given the patient's impaired memory and the unknown ingestion time of the pin, the exact cause will remain a mystery.

How can you ingest a sharp drawing pin? Probably the delirium had changed the perception of the pin into something appetising, or the patient had ingested it accidentally. Despite this plausible explanation and the many patients with a delirium at risk of ingesting foreign bodies, this problem has not been described in this subgroup before. Presumably it is often unnoticed by staff and unreported by the patient.

Ingestion of small objects is commonly reported in children as is the involuntary ingestion of (fish)bones in healthy adults. In psychiatric patients and prison inmates deliberate ingestion of foreign bodies is common.¹ Most

ingested foreign bodies pass spontaneously, usually over seven to ten days. Endoscopic or surgical intervention is indicated only when significant symptoms develop, necessary in 1 to 14% of cases.² Serious complications encompass bowel perforation, gastrointestinal bleeding, inflammation and obstruction.³ Risk factors are impaction at the level of the cricopharyngeus or oesophagus and a delayed presentation of more than two days after swallowing.⁴ Thin, sharp objects carry the highest risk of perforation.

In conclusion, just as people in a delirium can do unusual things, caregivers should consider unusual causes of symptoms and be aware of potential dangerous items in the rooms of delirious patients.

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