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They had to do it: A case series of compulsive insertions

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Introduction

The behavioural phenomenon of insertion of foreign objects into bodily orifices is common among young children which happens by accident and is a particular trait of Smith-Magenis syndrome.[1] In adults it may reflect risk taking behaviour, sexual experimentation or drug trafficking. It is a symptom manifestation of conditions including eating disorders, substance use disorders, factitious disorders, depression, dementia, Obsessive Compulsive Disorders (OCD), intellectual disability disorders and psychosis.[2] Most of the case reports detailing foreign object insertion in adults describe them as paraphilia or autoerotic mishaps leading to medical and surgical complications.[3,4] Although sexual obsessions are seen as a symptom in obsessive compulsive disorders limited literature exists on foreign object insertion as an OCD symptom. Here we present a series of cases presenting as compulsive insertion of foreign objects into bodily orifices.

Case 1

A 40 year old female was referred by Department of Pulmonary Medicine to whom she presented with the chief complaints of breathlessness, cough with sputum, sneezing and fever on and off from the past 8-10 months. On examination and evaluation, the patient was diagnosed as aspiration pneumonitis with left lung collapse. On further history taking, the patient reported to have an irresistible desire to stuff tobacco into her nose. Hence she was referred to Psychiatry department for further evaluation. Upon interview, the patient was found to have repetitive thoughts to insert some or other objects into her nostrils. This thought was intrusive and distressing which led to disturbed sleep and low mood in the patient.

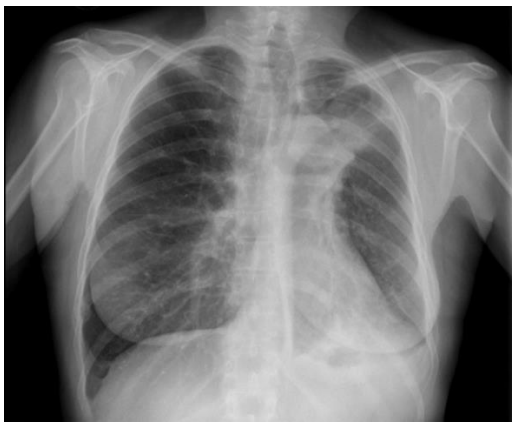

Fig. 1: X-ray chest showing left lung collapse.

Case 2

A 44 year old female was brought to the Psychiatry outpatient department by her husband with the chief complaint of compulsive insertion of cylindrical objects (pens, pencils, and straws) or even fingers into her throat since the past 2 months. On interview, the patient claimed to have repetitive intrusive thoughts of inserting objects down her throat which led to the compulsions. The patient was quite distressed with the thoughts and was anxious about her health condition. This distress was relieved only after inserting any object or fingers into her throat.

Fig. 2: Compulsive insertion of fingers into the throat.

Case 3

A 52 year old female patient was referred from Department of Gynaecology to whom she presented with the chief complaint of white discharge on and off since the past 1 month. Upon history taking, the patient revealed to have a constant urge to insert objects (vegetables, knob of hand-shower) into her vagina which has led to the present infection. She was referred to Psychiatry department for further evaluation. On interview, the patient reported to have repetitive unwanted thoughts which led to her compulsively inserting objects into her vagina. The patient denied any sexual gratification by the act. The patient was ashamed of her thoughts and actions and had suicidal ideations at the time of interview.

In all the above cases, on examination vitals were stable. The patients were alert and oriented at the time of the

act. They were cognitively intact and had average level of intelligence.

Upon questioning regarding their compulsive insertions, the patients reported to have had repetitive and intrusive thoughts to insert objects. The patients clarified that the insertions were not for sexual gratification or was not an intentional self-injurious act. On further inquiry, we elicited that though the repetitive thoughts were irrational, the patients could not resist them. The thoughts were recognised as their own and they denied of any hallucinations or delusions. The thoughts were identified to be obsessive in nature.

There was no history of any substance abuse or any medical comorbidity in the patients.

The patients were diagnosed as having obsessive compulsive disorder and were started on fluvoxamine and clomipramine. Patients were rated on Yale- Brown Obsessive Compulsive Scale (Y-BOCS). On their first follow up after two weeks, the patients claimed improvement of their symptoms. Further follow ups showed improvement both clinically and on rating scales.

Discussion

Obsessive-Compulsive Disorder (OCD) is characterised by the presence of obsessions and/or compulsions. Obsessions are intrusive and unwanted repetitive thoughts, urges, or impulses that often lead to a marked increase in anxiety or distress. Compulsions are repeated behaviours or mental acts that are done in response to obsessions, or in a rigid rule-bound way.[5] A feeling of anxious dread accompanies the central manifestation and the key characteristic of a compulsion is that it reduces the anxiety associated with the obsession. A patient with OCD realises the irrationality of the obsession and experiences both the obsession and compulsion as ego-dystonic (unwanted behaviour). The obsessions and/or compulsions are time consuming and interfere significantly with the person's normal routine, occupational functioning, usual social activities or relationships.[6]

The most common presentations of obsessions in adults are contamination, pathological doubt and need for symmetry. The most common presentations of compulsions are checking, washing, counting and need to ask or confess.[6] Insertions of foreign objects into the bodily orifices occur as a result of a variety of psychosocial and psychiatric states. Sexual gratification is commonly reported by patients as the reason for autoerotic or consensual sexual acts involving insertion of foreign objects into the urethra, vagina or rectum.[7,8]

Non-suicidal self-injurious behaviour is strongly associated with Borderline Personality disorder. Such behaviour seeks to modulate unbearable emotions, to externally mark for oneself or others an internal experience of being bad or simply to feel. Such non-suicidal self-injurious behaviour can take the form of insertion of foreign objections like 76 needles and hair pins self-inserted under the skin of woman's arms, head and neck which required surgical excision.[9]

A case study reported a patient with hypochondriacal delusion about having urethral strictures who inserted knitting needles into the urethra to overcome the feared stricture.[10] Insertions of foreign bodies have been reported in patients with malingering, factitious disorders, depressive disorders, substance intoxication and cognitive disorders. In one case series of 17 men with urethral insertions, substance intoxication was found in 6 of them.[11] A review of 8 dementia cases with foreign body insertion into the lower urinary tract revealed that 6 of those cases occurred in patients aging between 60-65 years.[12]

Though there is plenty of literature regarding insertion of foreign objects into bodily orifices as cases of sexual experimentation, drug trafficking, part of a Smith Magenis syndrome, paraphilias, and dementias the literature on insertion of foreign objects as obsessive compulsive disorders is quite sparse. Further research and studies are required in this regard.

Conclusion

Insertion of foreign objects into bodily orifices can occur due to various psychosocial and psychiatric conditions. Unfortunately such behaviour leads to medical morbidity in the patient (complications of object insertion, its surgical removal and its associated complications). In addition to considering the possibility of intellectual disability disorders, paraphilias, psychosis and dementias psychiatrists should also entertain the possibility of obsessive compulsive disorder as well when evaluating similar patients. Liaison with a surgeon or physician is imperative in order to achieve improvement in physical and mental health of such patients. Even in the absence of an underlying psychiatric disorder, harm reduction strategies can be taught to psychologically stable patients who embrace the insertion behaviour as a lifestyle preference.

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Conflict of interest

None.

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