SHORT REPORT

A case of coprophagia presenting with sialadenitis

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Abstract

Presentation: a 94-year-old woman with dementia was admitted to an acute geriatric ward with increasing confusion and falls. On two occasions she developed submandibular masses. Faeces were aspirated from her mouth and a diagnosis made of recurrent submandibular sialadenitis secondary to coprophagia.

Outcome: the submandibular mass settled with antibiotics and oral care. Coprophagia was not observed on the ward, but faecal smearing was noted. With regular toileting, this behaviour ceased and sialadenitis did not recur.

Keywords: coprophagia, dementia, scatolia, sialadenitis

Case history

A 94-year-old woman with dementia was admitted to an acute geriatric ward with increasing confusion and falls. She was pyrexial, dehydrated, disorientated and incontinent of urine and faeces. A mid-stream urine specimen grew *Escherichia coli* for which she was treated with intravenous antibiotics. A computed tomography scan of her brain showed generalized cerebral atrophy.

On the fourth day of her admission, she developed a left submandibular mass, which was hot and tender. The left submandibular duct was indurated and discharging. She was assessed by an otorhinolaryngologist, who diagnosed submandibular salivary gland infection, which resolved completely with antibiotics. Further investigations were contemplated but were not carried out due to her inability to co-operate. She remained disorientated and progressed poorly with rehabilitation.

Four weeks later, she developed a mass in the right submandibular area. She was again reviewed by an otorhinolaryngologist. Faeces were aspirated from her mouth. The tongue was swollen, there was mucosal ulceration and contact bleeding. The diagnosis was recurrent submandibular sialadenitis secondary to coprophagia. The submandibular mass settled with antibiotics and oral care. Coprophagia was not observed on the ward, but faecal smearing was noted on a few occasions during her admission. She was not constipated or receiving laxatives. With regular toileting, this behaviour ceased and sialadenitis has not recurred.

Discussion

Coprophagia, the eating of one’s own faeces, is an uncommonly reported symptom. There is little published information on this behaviour in adults. Its prevalence is unknown, its aetiology uncertain and approach to management undefined.

The characteristics of coprophagia in adults in psychiatric hospitals have been described [1]. In a study of 14 patients, average age 71 years, nine were demented, two had alcoholism, two had epilepsy, two were depressed and one had depression and cerebral atrophy; three had no clear cognitive deficit. All had normal serum thiamine concentrations.

A study of scatolia, the smearing of faeces, in long-stay psychogeriatric wards over 3 months identified 14 patients with this problem. All were incontinent of urine and faeces. Constipation was a common factor, leading to attempted digital evacuation by the patients. When they were treated with laxatives, their bowel frequencies returned to normal and smearing ceased [2]. Coprophagia was not described.

Coprophagia has also been described in patients with schizophrenia [3–5], obsessive compulsive disorder [6] and in the Klüver–Bucy syndrome [7, 8]. Dementia and features of Klüver–Bucy syndrome may coexist. Klüver–Bucy syndrome has been observed in

Complications of coprophagia include poor oral hygiene, chronic gingival infection [12] and chronic lesions on the mucosa of the vestibule secondary to retention of faeces [13]. Salivary gland infection has not been reported previously.

There is little information on the treatment of coprophagia. Strategies include behavioural therapy, treatment of psychiatric disorders and nutritional deficiencies, relief of constipation and pruritis ani, and maintenance of good oral hygiene. Carbamazepine has terminated the behaviour in a patient with a left fronto-temporal multiform glioblastoma [14] and in some cases of Klüver–Bucy syndrome [15, 16].

In conclusion, coprophagia is a complex behavioural disorder. Further study is needed to help us understand its mechanisms. This, in turn, may facilitate the development of behavioural therapy and drug regimes. The response of patients to carbamazepine suggests that specific brain lesions, as yet unidentified, may be responsible in some cases.

Key points
- Coprophagia, the eating of one’s own faeces, is a complex behavioural disorder about which we know little.
- Proposed causes of coprophagia, such as constipation, nutritional deficiency or underlying functional or organic brain disease should be sought, so that specific treatment can be given.

References

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