

Unusual foreign body Oesophagus

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ABSTRACT: Foreign body ingestion is common in paediatric age group with various complications. We report this case because of unusual shape of foreign body, its location in esophagus and removal through esophagoscope.

Key words: foreign body, esophagoscope, neck pendant

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INTRODUCTION: Foreign body ingestion in children is common between age groups 6 months to 3yrs. The common foreign bodies are coin, seed, nuts, toy, meat piece, fish bone etc in children. Most of the esophageal foreign bodies pass itself through the gastro-intestinal tract but some needs endoscopic or surgical removal. Here, we report a case of neck pendant with serrated outline as foreign body in the esophagus of an 1 yr old child which was retrieved through esophagoscope. The peculiarity of this case is unusual foreign body its location and age of the child.

CASE REPORT: A one year old male child came with his parents to the ENT OPD with the complaint of salivation,

drooling, dysphagia and mild cough. The mother complaint that child while playing swallowed neck pendant. The patient was immediately admitted, x-ray AP and LATERAL view (figure 1) was advised which showed foreign body in upper-mid esophagus. The endoscopic removal was planned under general anaesthesia. On examination, patient had pulse 110/min, blood pressure 110/70 mmHg, respiration 24/min. Patient had no stridor and no reduced air entry on both sides. Anaesthesia was induced with halothane and injection fentanyl 10 ug and oxygen. Inj Thiopentone 35mg with Atracurium 3.5ug was given and airway was secured with 4.5mm ID endotracheal tube. Removal with Magill's forceps was not possible due to location of

foreign body and anticipated tear and laceration of surrounding mucosa because of its shape. So, it was taken out with the rigid esophagoscope. Due to tracheal manipulation and rigid esophagoscopy ECG showed changes i.e. sinus tachycardia and bradycardia which settled itself after foreign body removal. There was no injury to the surrounding structure during manipulation. The neck pendant retrieved was about 3cm in length. Patient was reversed with inj neostigmine and glycopyrrolate and extubated on full return of spontaneous respiration. He was shifted to the ward for observation and discharged on the next day.

Figure1-AP & Lateral view of x-ray chest-



DISCUSSION: Eighty percent of all FB oesophagus occur in children, with a peak incidence in the age group of 6 months to 3 years. Of the FBs that come to medical attention, 80-90% passes through gastrointestinal tract without any difficulty, 10-20% requires endoscopic removal, and only about 1% requires surgical intervention. [1] The most common site for lodgment of an ingested FB is the cricopharynx. The FB in our case was lodged at the level of upper one-third of the esophagus.

Diagnosis becomes easier when parents give history of FB aspiration. X-ray neck, AP and lateral view, is most commonly done for diagnosis. If the incident is not witnessed and the ingested object is radiolucent, the

diagnosis of FB ingestion can be very difficult. Barium esophagoscopy, computed tomography scans of the neck, ultrasonography, and magnetic resonance imaging may be required for diagnosis. [2] In our case foreign body was easily visualized in x-ray.

Esophageal FB can damage the esophagus leading to perforations and strictures. Apart from eroding into the trachea, the object can erode into the aorta, leading to exsanguinations and death. [3] Other serious complications reported after FB ingestion includes abscess formation and even sudden death. [1] FBs should be immediately removed on diagnosis, because they may rapidly cause direct tissue damage (blackening, charring, liquefaction necrosis, and esophageal perforation), by pressure and by chemical and electrical burns. [4] The pendant in our case did not cause injury to the esophagus or trachea despite of serrations present on the its side , may be due to its removal without undue delay and also since parents noticed its aspiration because most of foreign body ingestion goes unnoticed causing serious sequel.

General anaesthesia with ET tube was used to secure airway in our case and to avoid aspiration of secretions. Pediatric endoscopy also often uses general anesthesia and

endotracheal intubation because smaller and more compliant airways, among other risk factors, can lead to a higher risk of airway obstruction during endoscopy. [5]

Conclusion- Foreign body suspicion should always be done in child with sudden onset of symptoms and emergent endoscopic removal planned to prevent complications due to its size, shape and location.

Figure 2: Neck pendant as foreign body



REFERENCES:

1. Wahebeh G, Wyllie R, Kay M. Foreign Body ingestion in infants and children, location. Clin Pediatr 2002;41 :633-40.
2. Young CA, Menias CO, Bhalla S, Prasad SR. CT features of esophageal emergency. Radio graphics 2008; 28:1541-53.
3. Jiraki K. Aortoesophageal conduit due to a foreign body. Am J Forensic Med Pathol 1996; 17:347-8.
4. Choudhry CR, Bicknell MC, MacIver D. Esophageal foreign body an unusual cause of respiratory symptoms in a three week old baby. J Otol Laryngol 1992; 106:556-7.
5. . ASGE Standards of Practice Committee, Lee KK, Anderson MA, Baron TH,et al. Modifications in endoscopic practice for pediatric patients. Gastrointestinal Endosc 2008;67:1-9.