

MANAGEMENT OF INGESTED FOREIGN BODIES

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Most foreign bodies ingested are lodged in the oropharynx and usually do not pose any difficulty in management. However, this cannot be said for foreign bodies in oesophagus. Oesophageal peristalsis is often weak and foreign bodies that get impacted are usually sharp and jagged. Hence spasm and mucosal odema over the foreign body can cause ulceration and necrosis of the oesophageal wall which may then perforate. This can result in serious complications, including retro-pharyngeal and para-oesophageal abscesses, mediastinitis and the invariably fatal oesophageal-aortic fistula which is fortunately rare. Hence the wait-and-see method which is justifiable for ingested foreign bodies in the other parts of gastro-intestinal tract should never be employed for oesophageal foreign bodies.

The symptom most characteristic of impacted foreign body is pain or discomfort in swallowing. It is important during the history taking to determine precisely the form of foreign object ingested and the site of pain or discomfort. Bones, particularly that of fish constitute about 90% of foreign bodies ingested in this part of the world. Most of the patients are adults. However in the West, foreign objects like coins and pins are just as common and they involve mainly children. Foreign bodies lodged or embedded in the oropharyngeal isthmus or valleculae usually refer the pain to digastric-jugular and submandibular region. Most of them can be seen on

mirror examination and present no difficulty in removal, if necessary under indirect mirror laryngoscopy with curved FB forcep. Pain elsewhere in the lower neck and chest does not correlate well with the level of impaction. Cricopharyngeus and cervical oesophagus is the commonest level for oesophageal foreign bodies to lodge. It is beyond laryngoscopic view and lateral XR neck is needed to diagnose a radio-opaque foreign body there. This film may also show widening of the retro-pharyngeal space, sometimes with presence of air suggestive of retropharyngeal abscess. Persistent discomfort, backache, chest or retrosternal pain indicates a swallow of contrast medium. Besides coating the foreign body and outlining radiolucent objects like denture and plastic (which do not show on plain CXR) contrast study is important as a prelude to oesophagoscopy if luminal disease or perforation is suspected. However, an embedded slender bone may show little or no mucosal abnormality. Hence in doubtful cases imaging by C T scan is invaluable in localising the suspicious level for foreign object embedded or which has already migrated outside the oesophageal wall.

The presence of foreign body may be indicated by history or pain alone. If any doubts remain, it is prudent to proceed to oesophagoscopy which would be conclusive. The flexible fiberoptic scope is an useful diagnostic tool but is generally not suitable for removal of foreign objects. Sharp impacted object may fissure and tear a length of the oesophagus when it is grasped and withdrawn together with the scope. Rigid oesophagoscope on the other hand allows the surgeon to withdraw the foreign body through the scope. The useful skill of rigid oesophagoscopy is unfortunately not easy to acquire and instrumental perforation occurs in 0.2 – 2% of cases. Particular difficulties exist with impacted large irregular objects such as denture with metal hooks. Severe lacerations of the oesophageal wall may result from forceful attempts to extract or push the foreign body distally. In these situations, open procedures like cervical oesophagostomy and thoracotomy are probably safer.

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