UNUSUAL FOREIGN BODY IN AIRWAY
TWO CASE REPORTS

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ABSTRACT
Tracheobronchial foreign body aspiration can be life threatening emergency, which is associated with significant morbidity and mortality. Aspiration of foreign bodies is common in pediatrics age group. The diagnosis and treatment of foreign bodies in airway are a challenge for ENT surgeon. Despite improvements in medical care and people awareness, approximately 3000 death occurs every year for foreign body aspiration. In this case report, we describe two interesting cases of unusual presence of foreign body. a) Cardboard pin in trachea, b) A dead Snail in the sub glottic region.

Keywords- Bronchoscopy, foreign body, trachea.

INTRODUCTION
Foreign body in airway still remain a diagnostic and therapeutic challenge despite significant advance in Endoscopic technique. It is very common in children below the age of 6yrs. Sudden aspiration of foreign body into airway may result in acute respiratory distress, chronic pulmonary infection, atelectasis and death. Diagnostic work up of foreign body aspiration include a definitive history and comprehensive radiological investigation.

Foreign body inhalation is best managed by rigid bronchoscopy which in expert hands is very simple, almost free of complications and successful. Sometimes foreign body in airway may present without any symptoms and normal chest radiograph. Here we are reporting two interesting cases of foreign body a) card board pin which was found inserted into tracheal wall and its plastic head was moving inside the tracheal lumen during respiration, b) A dead Snail in the sub glottic region. These foreign bodies were retrieved successfully by rigid bronchoscopy.

CASE REPORT: 1
An 8 yrs old boy accidentally inhaled a cardboard pin & developed bouts of cough, which settled after few minutes. He didn’t have any foreign body sensation in throat, haemoptysis, cough, chest pain or difficulty in breathing. Parents of the child believed the foreign body had been coughed out. Patient was brought to ENT OPD, Kalinga Institute of Medical Sciences after 5days on advice of a Pediatrician who was the family physician of that child. A detailed ENT Examination was done. Indirect Laryngology was normal. On respiratory system examination bilateral airway was normal and no added sound was found. X-ray of neck and chest was done immediately which revealed a linear metallic opacity over mediastinum area. Patient was taken up for pediatric rigid bronchoscopy under C-Arm guidance under general anesthesia. Luckily Red colored plastic head of the pin was visualized in the tracheal lumen just above the carina and was removed using
forceps. The post operative period was uneventful. Patient was discharged after 24 hours (Fig 1).

CASE REPORT: 2

A six year old boy accidentally inhaled a dead snail while playing with friends. He developed cough, mild respiratory distress. He was brought to the casualty of Hospital. Detailed ENT examination was done. There was bi-phasic stridor on close observation, bilateral air entry was normal. X-ray neck lateral view showed a radio opaque foreign body in subglottic area. Patient was taken to Operation Theater for removal under GA. With mask ventilation. On laryngoscope the foreign body was visualized in subglottic region. Endotracheal intubation was avoided as it could push the foreign body in to the bronchus. Tracheostomy was done and foreign body retrieved successfully. As it was a dead snail with a hole in it, air was passing freely in subglottic region. Tracheostomy was closed after 24 hours and child was discharged after 48 hours. Post operative period was uneventful (Fig 2, 3).

DISCUSSION:

Aspirated foreign bodies are responsible for a significant amount of mortality and morbidity in children despite the improvement in anesthetic and endoscopic technique. It is the 5th leading cause of death among children younger than 15 years. Toddlers seem to be the most vulnerable for foreign body aspiration with peak age of 1-3 years.3 According to the study conducted by Gross the clinical history in such cases was emphasized, especially the first paroxysm of notable cough and a severe suffocation which occurred with the aspiration of foreign object. There may be a symptomless period after first paroxysm which may vary in duration from few days to even months. However, subsequent wheezing, cough, choking and sudden onset of asthma points towards a possible foreign body aspiration. Plain X-ray chest remains the initial diagnostic modality. It has been reported that imaging studies have sensitivity
of 73% and specificity of 45%, though up to 20% of patient have negative history and negative radiological evaluation.

Advantage of rigid bronchoscopy for removal of tracheobronchial foreign body is already established due to its large lumen usage of alligator forceps for grasping. Assisted ventilation under GA is always comfortable and safe.

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