

Surgical removal of aswallowed foreign body, which has migrated into neck

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Abstract: Ingestion of foreign bodies is a common problem in paediatric population . Reports of extraluminal migration of the foreign bodies from the upper aerodigestive tract are rare. Penetration and extraluminal migration of ingested foreign bodies may cause severe vascular and suppurative complications, even death. We report a 4-year-old boy who presented with a Swelling in the neck. He had a history of ingestion of mesh of earphone speaker approximately 1 year ago. He had been asymptomatic until the present time. The examination revealed swelling in the left side of neck with fever and cough which has not relieved on medication. Direct laryngoscopy, cervical X-ray's, ultrasound neck and computed tomography scans were obtained. The foreign body was removed under general anesthesia. Surgical exploration of neck was done and foreign body removed. The patient recovered very well without any complications.

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I. Introduction

Foreign body ingestion is a common problem among pediatric populations. Most of the ingested foreign bodies pass naturally through the gastrointestinal tract, but 10–20% require nonoperative intervention and 1% or less require surgery .Even though there are numerous case reports of ingested foreign bodies of the upper aerodigestive tract, only a small number perforate the esophagus and an even smaller fraction migrate extraluminally. Most of these migratory foreign bodies reported so far have been fish bones and other sharp objects. The case described here is a report of an ingested foreign body migrating into the neck. This case highlights the possibility that relatively big blunt foreign bodies can also penetrate the mucosa, migrate extraluminally, and present as a foreign body in the neck.



II. Case report

A 4-year-old boy was referred to our institution with a Swelling in the neck.

Symptoms started 4 days ago with fever, cough and swelling on the left neck. A Ultrasound scan revealed a Radio opaque foreign body in the left prevertebral region at the paraoesophageal location with surrounding granuloma/abscess formation. Cervical X-rays show the presence of round coin shaped foreign body in the left neck and Computed tomography scans revealed Conglomerate Lobulated mixed echogenic lesion measuring approximately 39*22*34mm noted in left mid and lower neck region just posterolateral to left lobe of thyroid with adjacent inflammatory changes and loculated collections surrounding it. Video laryngoscopy showed normal laryngeal anatomy.

The family remembered that the boy swallowed the Mesh of earphone speaker approximately one year ago. He had been asymptomatic until the present time.

Physical examination revealed a firm swelling in left paraoesophageal location of neck with slight tenderness .

The patient had fever and cough not relieving on medication . The rest of the head and neck examination did not reveal any abnormalities. A blood sample examination revealed a raised white blood cell count 15,640/mm³) and a slightly elevated C-reactive protein level (2.2 mg/dL).

The patient was hospitalized after the initial examination and CT scan. An oral prophylactic antibiotic was administered. The foreign body was visible on lateral neck X-rays ,ultrasound and computed tomography scans didn't reveal any fistulous communication of foreign body with aerodigestive tract.

Direct laryngoscopy was performed which showed Larynx, cervical esophagus, and pyriform sinuses were found normal. The foreign body was removed by surgical exploration of neck under general anesthesia. The foreign body had surrounding granulation tissue and abscess formation was found behind the left lobe of thyroid adjacent to the aerodigestive tract. Foreign body was removed and the surrounding inflammatory tissue cleared . Hemostasis secured and a corrugated rubber drain was placed which was removed on the third post operative day. Patient recovered well without any complications.



II. Discussion

The incidence of ingested foreign bodies penetrating the esophagus and being extraluminal in the neck is fairly rare.

Ingested foreign bodies, especially fish bones, become lodged in the palatine tonsil, the base of tongue, the vallecula, the pyriform sinus, and the esophagus. Due to the direction and site of the migration of the foreign body, severe or even fatal complications may occur. These are aorto-esophageal



fistula, innominate esophageal fistula, subclavian esophageal fistula, carotid rupture, and local suppurative processes, such as periesophageal abscess, mediastinitis, retropharyngeal abscess, thyroid abscess, and deep neck abscess. In our case the ingested foreign body might have become lodged in the right pyriform sinus of the hypopharynx or in the cervical esophagus, penetrated and passed through the mucosa which healed over later, and migrated out of the neck after a silent period of 1 year. The plastic, blunt structure and smooth surface of the foreign body might have protected the patient from vascular and suppurative complications. This case report describes migration of a blunt foreign body removed by surgical exploration. Patients with foreign body aspiration or swallowing should be closely followed up. Besides history and examination, radiology is an important tool to detect foreign bodies and their location. CT scan can be effectively used to locate foreign bodies. A mass or an abscess in the head and neck region could be an outcome of a migrated foreign body. Therefore a thorough history must be obtained and an ingestion of a foreign body must be questioned.