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A Retrospective Study of 100 Cases on Foreign Body Oesophagus

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Abstract: *Foreign bodies of esophagus and food particular history are common problem in emergency Department of Otolaryngology. Children & old age people are mostly affected. Most of the F. B. Are not dangerous but some like cell battery due to corrosive side effect are dangerous. Acute dysphagia occurs which is life threatening. Sharp objects like safety pin, blades etc. are more harmful as for patient also for the surgeon for the procedure. Overall F. B. are not safe.*

Key word- *F. B., denture, esophagoscopy.*

1 .INTRODUCTION –

Foreign body ingestion is common in children, but frequently
seen among adults also[1]. Esophagus foreign bodies are common problem in emergency, most of them seen in children &old age. In young adult with history of alcohol drinks, edentulos condition or also with psychiatric patients was noted [2,3]. Some F. B. Are specific according to age like coin found in children's, dentures are in old age, meat bolus in young adults with alcohol history. Some F. B. Are dangerous like battery, sharp objects like open safety pin, blade they causes esophageal perforation if not prediction during esophagoscopy and also remove immediately on emergency basis [4]. Coins are safe F. B. They can be safety removed or under spontaneous passage from stool also. Food bolus may be history with patient of stricture, malignancy, or cardio achalasia etc. So, foreign body removed under planned way for good results.

2**. METHODS**-

Total number of patients were 100 in my Retrospective study from 2010-2016 in GMC kota in ENT Dept. on foreign body oesophagus.

History of patient for foreign body ingestion, dysphagia, odynophagia, saliva drooling was positive or negative. I also do indirect laryngoscopy for polling saliva or post cricoid malignancy special. Female patient.

In children also watch the respiratory distress due to compression of Trachea by foreign body. Neck and Chest x-ray from anterior posterior and literally view for Confirmation of foreign body whether it is in oesophagus or trachea, also site detention for Impact in of body, also help full in access neck or other disease. We always do rigid endoscopy in General anesthesia in planned or emergency for removed of foreign body. Procedure was done according to patient conditions and type of foreign body. Like sharp material, battery cells was urgently done in emergency operation theatre. Absolute obstruction or dysphagia also do in emergency but coin which was partially obstructed, was done in planned way. Or some foreign body which was insert, lower part, non-obstructive was waited and they spontaneously passage from stool without any procedure. After all oesphagoscopy we will recent for any other or more foreign body, perforation, stricture, growth, malformation, diverticulum etc. Also do check x-ray before discharge or before starting found or solid from mouth then discharge if all will be normal.

3. RESULTS-

Total no. of patient taken 100 from 2010-2016 in G.M.C. Kota under the guidance of Dr.Rajkumar jain (prof. & Head) and Dr. Vijay Kumar Meena (asso. Prof.) .in that

1. Sex wise distribution

Male are 62& 38 were female patients.

2. Age wise distribution –

0-10 years = 63 patients

10-40 years= 13 patients

Above 40 = 24 patients

3. Operation manner

Planned way- 78 patients

Emergency operation theatre- 22

4. Types of Foreign Bodies in total cases

Coins- 69 case

Meat or Food bolus- 18 case

Denture- 9 case

Battery cell- 3 case

Kancha- 1 case

5. Site where these foreign bodies found in oesophagoscopy

At cricopharynx- 55 (most common site)

Tonsillar or oropharynx- 10

Mid oesophagus- 22

Lower end- 13

Thus by this study we found that most common F.B. In children are coin and in adults Food bolus. Sometimes we found cell that was corrosive in nature is, dangerous might be mucosal injury or perforate the oesophagus, so do as early as possible. Some time we found double kancha (glass ball).after the oesophagoscopy we found mucosal injury in 2 cases and perforation in one case noted but by the bless of god they are now very good condition.

Before 2010 here also done a case of multiple foreign body in 10 day female child and a prisoner cut blade in oesophagus.

4. DISCUSSION-

F.B. ingestion common in children & in old age, because of everything putting in mouth by child. Also sometime incidentally. Coin is most common foreign body found in children [5]. Dentures are common in old age people with history of alcohol ingestion. Little child & psychotic patient doe not give history of foreign body ingestion but older children & young adults give proper history.so on the basis of history and clinical picture as vomiting, pain, saliva drooling, dysphagia, choking, respiratory distress [6] etc helpful for oesophagoscopy procedure.

For identifying the foreign bodies radiological investigation are important. For size, site, shape etc. Also give about the complication like cellulitis, abscess, gas shadow etc. x-ray neck and chest anteroposterior and lateral view helpful for diagnostic. Some foreign bodies as fish bone, wood stick, plastic not seen in X-ray.so, we don't discourage and do the oesophagoscopy carefully on basis of sign [7] & symptom.

Type of foreign bodies also important for doing oesophagoscopy. Severity of dysphagia (absolute/partial),pain, aspiration risk, age of patients, duration of ingestion, margin of F.B. also helpful of doing oesophagoscopy. Sharp objects due to fear of perforation [8] oesophagoscopy do early . For the coin must watch spontaneously passage. Button battery is emergency, but as duration increases risk of complication also increases [9].

Oesophageal F.B. also removed by either flexible or rigid endoscope. With flexible endoscope it is done with sedation only. Also less complication like perforation [10]. Rigid endoscope have more success but chances of complications are also more.we can use various tool like dormia basket, crocodile forceps, peanut forcep. But all of them rigid endoscope is an effective & safe for removal foreign body if handled with good otolaryngologist. Rigid endoscopic removal of foreign
body is safe and effective, but often requires GA **[11]**. Another method is pushing the foreign body into the stomach with a bougie. [12].

5. CONCLUSIONS-

Children and old age people is common for foreign body ingestion. Coin in children, food bolus in in adults are comment foreign bodies. Alcohol also in history with meat bolus. On the basis of sign and symptoms we do oesphagoscopy besides normal history or only suspicion of foreign body. Small asymptomatic, insert, nontraumatic foreign body may watch for spontaneously passage. Sharp, irregular surface margin and corrosive foreign body and absolute dysphagia patient should be removed earliest in emergency operation theatre for avoiding complications such as perforation, stricture or may be death. So, Rigid esophagoscopy under gernal anesthesia is best effective and safe method. Rigid scope is preferred for
removal of sharp and penetrating foreign bodies [13].

6. REFRENCES-

1. Sanowski RA. Foreign body extraction in the gastrointestinal tract. *In*: Gastroenterological endoscopy, ed. Sivak MV., W.B. Saunders Co: Philadelphia; 1987. p. 321-31.

2. Palta R, Sahota A, Bemarki A, et al. Foreign-body ingestion: characteristics and outcomes in a lower socioeconomic population with

predominantly intentional ingestion. Gastrointest Endosc 2009;69:426-33.

3. Weiland ST, Schurr MJ.Conservative management of ingested foreign bodies. J GastrointestSurg 2002;6:496-500.

4. Litovitz EL, Schmitz BF. Ingestions of cylindrical and button batteries: an analysis of 2382 cases. Pediatrics 1992;89:747-57.

5. Wyllie, R. Foreign bodies in the gastrointestinal tract. CurrOpinPediatr 2006; 18:563.

6. Hachimi-Idrissi S, Come L, Vandenpias Y. Management of ingested foreign bodies in childhood: our experience and review of the literature. Eur J Emerg Med 1998;5:319-23.

7. Ginsberg GG. Management of ingested foreign objects and food bolus impactions. Gastrointest Endosc 1995;41:33-8

8. Rosch W, Classen M. Fiberendoscopic foreign body removal from the upper gastrointestinal tract. Endoscopy 1972;4:193-7.

9. Loh KS, Tan LK, Smith JD, et al. Complications of foreign bodies in the esophagus. Otolaryngol Head Neck Surg 2000;123:613-6.

10. Gmeiner D, von Rahden BH, Meco C, et al. Flexible versus rigid endoscopy for treatment of foreign body impaction in the esophagus. SurgEndosc.2007;21:2026-9.

11. Giordano A, Adams G, Boies L, Meyerhoff W. Current management of esophageal foreign bodies. Arch Otolaryngol 1981;107:249-51.

12. Bonadio WA, Jona JZ, Glicklich M, Cohen R. Esophageal bouginage technique for coin ingestion in children. J Pediatr Surg 1988;23:917-8.

13. Holinger LD. Management of sharp and penetrating foreign bodies of the upper aerodigestive tract. Ann Otol Rhinol Laryngol 1990;99:684-8.