

Case Report

A case report on two superimposed foreign body coins in esophagus

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ABSTRACT

Foreign body ingestion is a common occurrence. We report a case of 8 year old male who presented with history of foreign body ingestion (coin). He had frequent episodes of vomiting along with foreign body sensation. Later on two superimposed foreign body coins were removed by rigid oesophagoscopy.

Keywords: Coin, Foreign body, Oesophagus, Superimposed

INTRODUCTION

We report a case of foreign body ingestion and inhalation occurs in paediatric age group. Foreign body (FB) ingestion is a frequent occurrence in children with a peak in children older than 3 years.^{1,2}

When any patient have history of ingested foreign body, investigation is mandatory regardless of the age or apparent absence of signs and symptoms.³

A large number of foreign bodies especially coin pass spontaneously without causing any damage. The ingestion of multiple foreign bodies in the form of coin is relatively rare phenomenon. The need for intervention depends in size, shape, and location etc. of foreign body.

CASE REPORT

We report a case of 8 year old male child who presented to Department of ENT, S.S. Medical College, Rewa, M.P. with the complaints of vomiting and foreign body sensation since 6 hours. There was no history of odynophagia, dysphonia, throat pain or respiratory distress. As per patient's father child was apparently

alright and playing at home. Then suddenly he started vomiting and was quite frightened with pale look. He had three episodes of vomiting further which consisted of food particles mainly. On further enquiry and prior assurance to patient he revealed that he kept one 2 rupees coin in mouth to prevent his other pals from snatching his coin. He also complained of foreign body sensation and revealed that he hid this foreign body because of the fear of scolding from parents. He tried to remove the foreign body but was with an unsuccessful attempt. The patient presented in emergency ward and was later referred to ENT department for further diagnosis and management.

On careful examination there was no abnormality in mouth and throat. Respiratory rate was normal. On auscultation air entry was bilaterally equal with no signs of cyanosis or adventitious sound. The radiograph of neck in anteroposterior view revealed the disc shaped circular foreign body as suspected. But to our surprise the soft tissue radiograph of neck lateral view revealed foreign body in oesophagus at the level of sixth and seventh cervical vertebra (C6 and C7) and first thoracic vertebra (T1) which appeared to be double and superimposed because of irregularity of border of coin (Figure 1). The child was once again enquired about the

coin ingestion but he refused ingestion of two coins. This led to a state of confusion further. Later under general anaesthesia a rigid oesophagoscope was inserted and a foreign body coin was visible. The foreign body was held with forceps and then removed carefully avoiding damage to surrounding structures. No intraoperative complications were seen. As suspected from radiographs two coins i.e. one rupee and two rupee coins stuck with mucus were retrieved (Figure 2). The oesophagus was inspected again on the basis of clinical suspicion but no foreign body was seen this time.

The patient was then kept under observation under antibiotic and analgesic cover. Postoperative event was uneventful. The patient was stable and discharged later on with adequate medical advice.



Figure 1: X-Ray neck lateral view showing two superimposed coins.



Figure 2: Showing retrieved foreign body.

DISCUSSION

Foreign bodies in the aerodigestive tract are common occurrences and need to be handled carefully with prompt management by skilled and experienced hands to avoid disastrous consequences. A foreign body impacted in the oesophagus requires immediate attention and treatment.

Oesophageal foreign bodies are most frequently located at the level of the cricopharyngeus muscle, the narrowest portion of the oesophagus.^{4,5} Similarly in the present case the foreign body was found lodged in the cricopharyngeal region.

Situation becomes difficult because of the vague history and complaints. As in our case the child was reluctant enough to reveal the entire history which made diagnosis of multiple coins difficult and led us to believe that it could be entirely a different foreign body from a coin.

As per a clinical study two radiological views are recommended in the assessment of oesophageal foreign bodies.⁶ Radiographs of the neck in anteroposterior and lateral views should be performed in cases of foreign body ingestion or inhalation wherever possible. Lateral neck radiographs or computed tomographic imaging should be considered to identify air in the retropharyngeal area.⁷ The foreign body was clearly demarcated in the lateral view of the soft tissue neck at the level of the sixth and seventh cervical vertebrae and the first thoracic vertebra (C6, C7 and T1). Lateral radiography played a vital role in the suspicion of a double foreign body at the same location in our case.

Rigid oesophagoscopy is a safe and effective procedure for foreign body removal from the oesophagus. Other modalities of treatment involve removal with a laryngoscope in case of foreign bodies impacted in the pharynx, hypopharyngoscopy for hypopharyngeal foreign bodies and less easily foreign bodies are removed using a flexible esophagoscope.⁸ In the present case rigid oesophagoscopy was done under general anaesthesia and foreign body removal was performed with forceps.

CONCLUSION

The occurrence of multiple foreign bodies should be carefully enquired while eliciting history and appropriate investigations done before reaching a final diagnosis. This helps in planning an appropriate strategy during removal of a foreign body. Serial radiographs could be advised if multiple foreign bodies are suspected to diagnose the exact location.

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