



A Review on Foreign Body Obstruction in Throat and A Case of Molar Tooth in Esophagus

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Abstract

The ingestion of various foreign bodies that causes respiratory trouble and dysphagia is a worldwide problem among all age groups. Securing the airway by tracheostomy is imperative, and direct laryngoscopy gives prompt analysis. The significance of the contributory history and its perception is accentuated in the findings and early treatment. Foreign bodies in the ear, nose, and throat are at times found in family pharmaceutical, ordinarily in children. The most widely recognized foreign bodies are bits of food, plastic toys, and little family things. Determination is frequently postponed in light of the fact that the causative occasion is generally in secret, the manifestations are nonspecific, and patients are frequently misdiagnosed at first. Most remote bodies in the ear and nose can be removed by a talented doctor in the workplace with negligible danger of inconveniences. Normal evacuation techniques include the utilization of forceps, a water system, or a suction catheter. Foreign bodies in the pharynx or trachea are medical crises requiring surgery. Radiography is regularly prescribed. Adaptable or inflexible endoscopy as a rule is required to affirm the diagnosis and to expel the foreign body. Doctors need to employ a large amount of doubt for foreign bodies in children with unexplained upper airway side effects. It is essential to get it the life systems and the signs for subspecialist referral. Sufficient proof to make solid proposals for particular expulsion strategies is lacking.

Keywords: Tooth, Fish Bone, Foreign Bodies, Emergency, Airway, Stridor, Obstruction, Tracheostomy

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Introduction

Ingestion of a foreign body is a typical issue among all age groups and especially in infant children and toddlers as they tend to put anything in their mouths which might result in the item being unintentionally swallowed. These bodies may become lodged in the tonsil, base of the tongue, piriform fossae, or the throat; they may also lodge somewhere in the larynx or farther down in the respiratory tract, prompting therapeutic/surgical crises which are frequently difficult for an otorhinolaryngologist to correct. Many foreign bodies that get stuck in the pharynx typically lodge near the cricopharynx, down in the bronchi, or even lower at the point where the larynx is narrow. Infrequently, foreign bodies in the larynx may become fatal. Analysis depends on the patient's history and clinical and radiological examination. Depending upon the age, a great assortment of foreign bodies, such as coins, marbles, catches, batteries, bottle tops, peas, beans, grains, or seeds in babies and toddlers, and bones, dentures, and metallic pins/wires more frequently in adults have been reported.¹ While a fish bone may be the most common foreign body to lodge in the pharynx of adults, live fish wedged in the throat

has also been reported.^{2,3} The reported 6 patients, 2 children and 4 adults, had an assortment of foreign bodies wedged at different levels of the oro-pharyngo-larynx, each with various clinical introductions.⁴

Condition

The patient usually feels as if he has swallowed a fish or chicken bone, a pop top from an old-style can, or something of the sort, and can still feel a foreign body sensation in his throat, especially (perhaps painfully) when swallowing. He may be convinced that there is a bone or other object stuck in his throat. He may be able to localize the foreign body sensation precisely above the thyroid cartilage (implying a foreign body in the hypopharynx which is possible to see), or he may only vaguely localize the foreign body sensation at the suprasternal notch (which could imply a foreign body anywhere in the esophagus). A foreign body in the tracheobronchial tree usually stimulates coughing and wheezing. Obstruction of the esophagus produces drooling and spitting up of whatever fluid is swallowed.⁵

What to Do

It is important to establish exactly what item was swallowed, when it was swallowed, and the progression of symptoms since swallowing. Patients can accurately tell if a foreign body is on the left or right side. If symptoms are mild, the patient's ability to swallow should be tested using a small cup of water first and then a small piece of bread. In this way, it can be determined what symptoms are reproduced; the bread may possibly eliminate the sensation of the foreign body. The patient's chest should be percussed and auscultated. A foreign body sensation in the throat can be produced by a pneumothorax, pneumomediastinum, or esophageal disease, all of which may show up on a chest x-ray.⁶ With the patient sitting in a chair, the oropharynx should be inspected with a tongue depressor for foreign bodies or abrasions. The hypopharynx should be inspected with a good light or headlamp mirror and special attention paid to the base of the tongue, tonsils, and vallecula where foreign bodies are likely to lodge. Visibility should be maximized and gagging minimized by holding the patient's tongue out (using a washcloth or a 4×4 piece of gauze for traction and taking care not to lacerate the frenulum of the tongue on the lower incisors) and having the patient raise his soft palate by panting "like a dog." This may be accomplished without topical anesthesia, but if the patient is skeptical or tends to gag, the soft palate and posterior pharynx may be anesthetized with a spray (cetacaine, Hurracaine, or 10% lidocaine) or by having the patient gargle with viscous xylocaine diluted 1:1 with tap water. Some patients may continue to gag even with the entire pharynx anesthetized. If a foreign body or an abrasion of the mucosa is found, the problem may have been identified. A small fish bone is frequently difficult to see. It may be overlooked entirely except for the tip, or it may look like a strand of mucus. If the object can be seen directly, it should be carefully grasped and removed with bayonet forceps or a hemostat. Objects in the base of the tongue or the hypopharynx require a mirror or indirect laryngoscope for visualization. Fiberoptic nasopharyngoscopy is preferred when available. Further treatment is probably not required, but the patient should be instructed to seek follow-up if pain worsens, fever develops, breathing or swallowing is difficult, or if the foreign body sensation is not totally resolved in 2 days. If the diagnosis is not satisfactory to the doctor or the patient, a soft tissue lateral x-ray of the neck may be performed.⁷ This x-ray will probably not show radiolucent or small foreign bodies, such as fish bones or aluminum pop tops, but it may point out other pathology, such as a retropharyngeal abscess, Zenker's diverticulum, or severe cervical spondylosis, which might account for the symptoms (and allow some time for the patient's gag reflex to settle down, in case the hypopharynx could not be inspected on the first try). Lateral soft-tissue x-rays can be very misleading, because ligaments and cartilage in the neck calcify at various rates and patterns. The foreign body seen on a plain x-ray may simply be normal calcification of thyroid cartilage. A barium swallow may be warranted, if available, so as to demonstrate with fluoroscopy any problems with swallowing motility or perhaps to coat and thus visualize a radiolucent foreign body. It must be noted that endoscopy is

technically difficult after barium has coated the mucosa and possibly obscured a foreign body. It may be preferable to use a water-soluble contrast (e.g., Gastrographin), but even under the best of circumstances, contrast studies are of limited value. Rigid laryngoscopy, esophagoscopy, and bronchoscopy under general anesthesia should be reserved for the few cases in which the suspicion of a perforating foreign body remains high (e.g., when the patient has moderate to severe pain, is febrile or toxic, cannot swallow, is spitting blood, or has respiratory involvement). If x-rays are negative and careful inspection does not reveal a foreign body, and the patient is afebrile with only mild discomfort, the patient may be sent home and observed. The patient should be reassured that a scratch on the mucosa can produce a sensation that the foreign body is still there, but that if the symptoms worsen the next day or fail to resolve within 2 days, he may need further endoscopic studies.⁸ If there are any continued symptoms, the patient should have an otolaryngology referral and consultation within 2 to 3 days.

What not to Do

It should not be assumed that a foreign body is absent just because the pain disappears after swallowing local anesthetic. The patient should not be reassured that the presence of a foreign body has been ruled out if that is not the case; instead, the most likely situation should be explained to the patient, and the patient should be told why invasive evaluation is more dangerous than careful follow up. Preexisting pathology incidentally discovered during swallowing should not be ignored. Moreover, removal of the foreign body should not be blindly attempted with a finger or instrument, as the object may be pushed farther down into the airway and obstruct it or cause damage to surrounding structures.⁹

Discussion

During swallowing, as the base of the tongue pushes a bolus of food posteriorly, any sharp object hidden in that bolus may become embedded in the tonsil, the tonsillar pillar, the pharyngeal wall, or the tongue base itself. In one study, the majority of patients presenting with symptoms of an impacted fish bone had no demonstrated pathology, and their symptoms resolved in 48 hours. Twenty percent of patients did have an impacted fish bone, and the majority of these were easily identified and removed on initial visit.¹⁰ All patients who complain of a foreign body in the throat should be taken seriously. Even relatively smooth or rounded objects that remain impacted in the esophagus have the potential for serious problems, and a fish bone can perforate the esophagus in only a few days. Impacted button batteries represent a true emergency and require rapid intervention and removal, because leaking alkali produces liquefactive necrosis. A pill composed of irritating medicine (e.g., tetracycline) swallowed without adequate liquid may stick to the mucosa of the pharynx or esophagus and cause an irritating ulcer.¹¹ Bay leaves, invisible on x-rays and laryngoscopy, have lodged in the esophagus at the cricopharyngeus and produced severe symptoms until removed with a rigid endoscope. The

sensation of a lump in the throat unrelated to swallowing food or drink may be globus hystericus, which is related to cricopharyngeal spasm and anxiety. The initial workup is the same as with any foreign body sensation in the throat.

Conclusion

Most patients with oropharyngeal or laryngeal foreign bodies need to be overseen in an arranged way without freeze. A contributing history and careful clinical examination are basic procedures in suspected cases. When breathing is hampered, securing the airway by tracheostomy is of the most extreme significance. It is concluded that immediate laryngoscopy under general anesthesia will give a quick conclusion in every single presumed case, and the foreign body can be evacuated effortlessly.

Authors' Contributions

All authors contributed equally to this study.

Conflict of Interest Disclosures

The authors declare that they have no conflicts of interest.

Ethical Approval

Not applicable.

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