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CASE REPORT

Unusual aero-digestive foreign bodies: Tribulations and tragedies

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Bronchoscopy;
Esophagoscopy;
Foreign body ingestion;
Bronchiectasis;
Empyema thoracis

Summary Aero-digestive foreign bodies are a common occurrence in infants and children. The manifestations, hazards and consequences depend upon the location, nature of the foreign body and the time lapse. This communication reports a series of four cases with unusual course and consequences of aero-digestive foreign bodies. These were generalized tetanus, hypernatremia and metabolic acidosis with intracranial hemorrhage and severe pneumonia and empyema. Awareness of these consequences would help treating doctors to take appropriate steps in devising preventive and therapeutic strategies.
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1. Introduction

Children are prone to aspirate or ingest foreign bodies (FB). The highest incidence of aspiration is seen in infants younger than 2 years of age [1]. Though foreign body aspiration can be life-threatening, foreign body ingestion is relatively benign. In a majority of cases the ingested foreign body is passed uneventfully in stools. Instances of ingested foreign bodies leading to complications are uncommon, most resulting from impaction, injury by sharp objects or during the removal procedure. The series of four cases reported here illustrate unanticipated hazards of unusual foreign bodies of an apparently benign nature.

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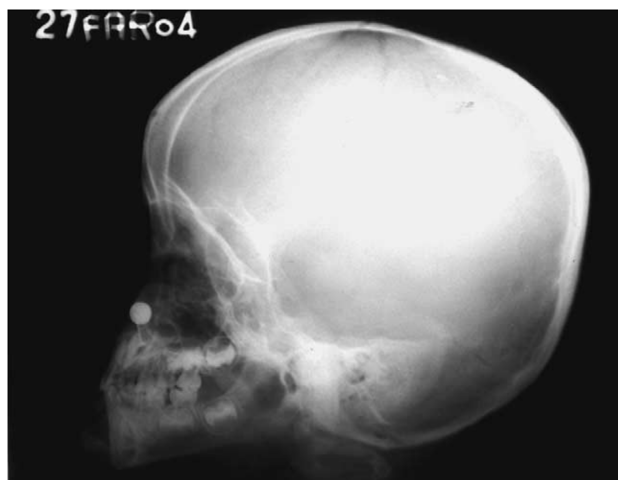

Fig. 1 Lateral radiograph of the skull showing a radio-paque disc shaped object overlapping the nasal spine.

2. Case reports

2.1. Case 1

A 3-year old boy was admitted with inability to open his mouth and difficulty in feeding for the past 2 days. Twenty days back, he had inserted a button battery from a wrist watch in the left nasal cavity, which had led to a painful swelling of the nose. The foreign body was eventually removed 16 days following insertion of the object after a lateral skull radiograph demonstrated a disc-shaped object lying over the anterior nasal spine (Fig. 1). Although the mother reported that the child had received three primary doses of Diptheria—Pertussis—Tetanus (DPT) vaccine and a booster immunization at 18 months of age; no documentary proof was available. The child did not receive any immunization against tetanus following the impaction or removal of the nasal FB. On physical examination, the vital parameters were normal. Blood pressure (BP) recorded was 130/90 mmHg. A diagnosis of generalized tetanus (moderate grade, score 10) was made on the basis of presence of spasms, positive spatula test, neck rigidity, trismus, and rigidity of limbs and abdominal muscles [2]. He was treated with 3000 IU of tetanus immunoglobulin administered intramuscularly (i.m.), tetanus toxoid (0.5 ml, i.m.), intravenous (i.v.) benzyl penicillin (50,000 IU/kg/dose 6 hourly i.v. for 7 days) and metronidazole (10 mg/kg/dose 8 hourly i.v. for 10 days). The spasms and rigidity were controlled by administration of diazepam (60 mg/kg/day for 33 days, oral), phenobarbitone (5 mg/kg/day in two divided doses for 33 days, oral), chlorpromazine (up to 3 mg/kg/day in three divided doses for 25 days, oral), midazolam (0.5 μg/kg/min for 25 days, i.v. infusion) and baclofen (0.5 mg/kg/dose 8 hourly for 6 days, oral). The spasms were controlled over 24 days. The sedative doses were gradually tapered. At discharge on day 50 of hospitalization, the patient was asymptomatic and there were no sequels.

2.2. Case 2

A 30-month old mentally retarded boy was admitted for evaluation of recurrent respiratory infections since six months of age. These episodes, characterized by cough and breathlessness, occurred every 2—3 months. They were relieved by administration of inhalations and oral medications. The mother did not recall any episode of sudden choking, coughing or stridor. On physical examination, the child had failure to thrive and clubbing. The respiratory rate was 28/min but there were no signs of respiratory distress. Auscultation of the chest revealed reduced breath sounds and crepitations over the left axillary and inter-scapular areas. Based on symptoms of recurrent respiratory infections since early infancy, failure to thrive, clubbing and localized chest signs in a mentally subnormal child; diagnostic possibilities of immunodeficiency disorders, recurrent aspirations and foreign body inhalation (missed foreign body) were considered. The chest radiograph showed an object with crenated edges on the left side with changes suggestive of bronchiectasis in the

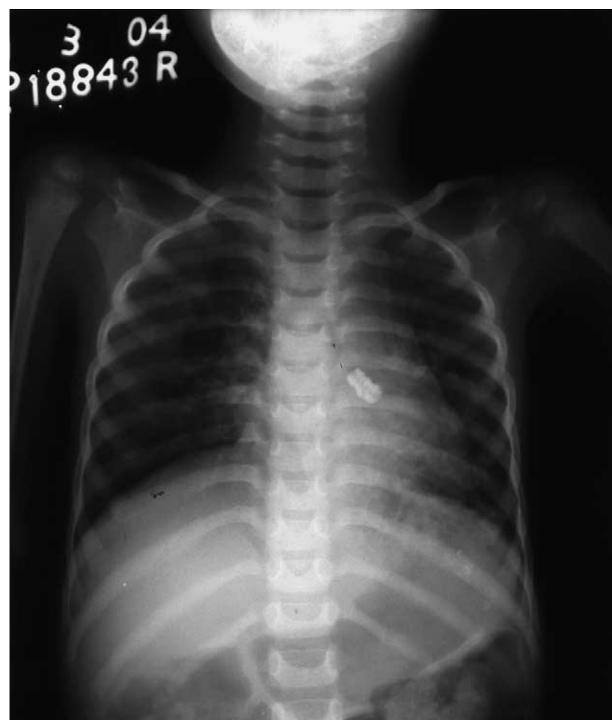

Fig. 2 Chest radiograph showing a crenated hollow object to the left of the sixth thoracic vertebra.

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