CASE SERIES

Atypical Foreign Bodies in ENT: A Case Series in A Tertiary Care Hospital

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ABSTRACT

Foreign bodies in ENT can be of varied types, presenting in different age groups, located at different sites. The ears are the most common site for foreign bodies followed by the nose and throat, The age group is below 10 years in most of the cases. They present with varying symptoms ranging from aural fulness to life threatening scenarios of aspiration or stridor in case of bronchial or esophageal location. Objects detected as foreign bodies in the ear and nose include bead, peanuts, paddy seeds, ball rings, paper and plastic. Coin, chicken bone and fish bone have been found in the esophagus. They require skilful removal by trained ENT surgeon in the first attempt as more manipulation will lead to complications and the need for general anaesthesia.

Keywords: Foreign bodies, safety pin, coin, peanut

INTRODUCTION

One of the most common ENT emergencies are foreign bodies accounting for more than 20% of cases. A foreign body is an object or a substance that gets accidentally or intentionally positioned in a particular anatomical site. They are more common in children due to behavioural factors such as curiosity and exploratory habits.[1]

The clinical presentation varies depending on the location and type of foreign body. The foreign body can be classified as vegetative and non -vegetative. The non vegetative are usually inanimate objects, such as balls, pins and metallic rings.[2] The vegetative objects are organic substances which have a tendency to swell up due to their hygroscopic nature. This hydrophilic tendency makes them more formidable as they are more prone to get stuck. The severity of symptoms depends upon the site and type of foreign bodies. Inanimate foreign bodies in the ear may, at times, be asymptomatic, while, animate objects like insects in the ear will definitely cause severe discomfort. Similarly, some nasal foreign bodies may remain undetected for many years leading to rhinolith formation with only unilateral nasal obstruction and discharge. Hence unilateral nasal discharge in a child should alert the clinician about the possibility of nasal foreign bodies. Nasal foreign bodies also pose the challenge of getting displaced posteriorly and entering the airway. Pharyngeal and airway foreign bodies are an acute emergency as they present with stridor or dysphagia.

Most of the foreign bodies can be removed by skilled ENT surgeon using ball probe, syringing and forceps. But esophageal and bronchial foreign bodies require removal under anaesthesia.[3-4]

Here we are highlighting some of the atypical foreign bodies removed which required operative intervention over a period of 6 months from Nov 2025 to April 2026.

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Case 1

A 13year old female presented to our OPD with history of safety pin inserted in the nose. There was history of prior instrumentation in some other hospital. Anterior rhinoscopy revealed blood clots in the right nostril. On X-ray it was found to be an open safety pin which was stuck in the nasal cavity. She was taken up for removal of foreign body in emergency OT under general anaesthesia. (Figure 1a, b, c)

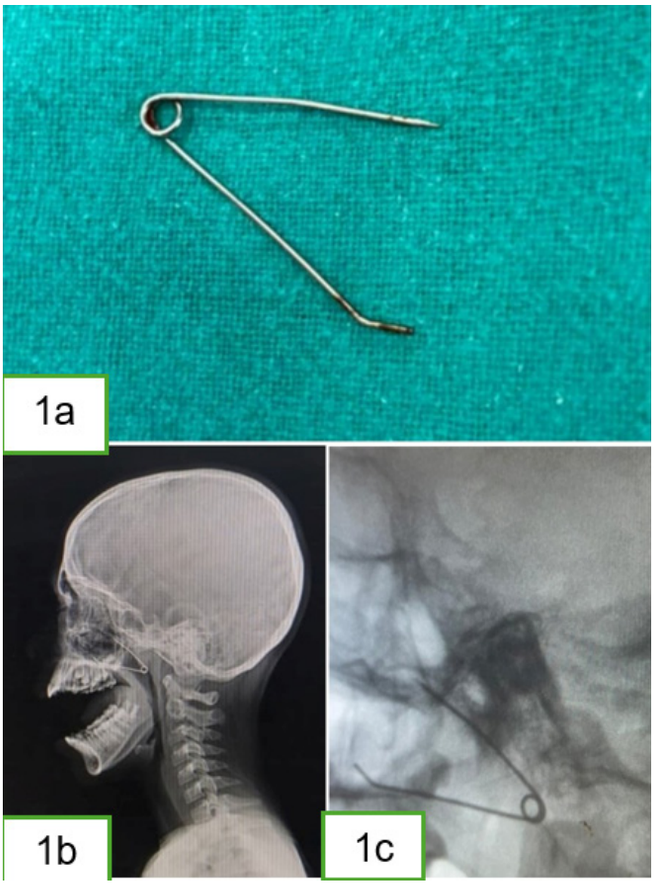


Figure 1: (a) Showing the open safety pin after removal (b) showing the preop Xray (c) showing intra-op C-arm done to confirm that the object has not been displaced.

On endoscopy only one tip of the safety pin was seen lying on the floor of the nasal cavity. The other end was found to be lodged beyond the superior turbinate with one end in the eustachian tube opening. The end was exhibiting pulsations transmitted from the carotid artery. Since removal from anterior end was difficult owing to inferior turbinate hypertrophy and narrow nares, it was decided to push the pin posteriorly towards the oropharynx. Keeping the throat pack in situ, it was palpated intraorally beyond the uvula and carefully removed by upturned forceps from the oropharynx. The patient was admitted for 2 days and discharged. On follow up visit after 2 weeks the nasal cavity was found healthy. (Figure 2a, b, c)

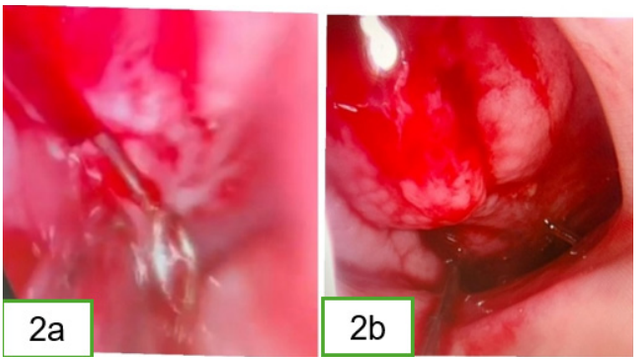


Figure 2: (a) Showing the intra-op view of the pin near the eustachian tube (b) showing the pin displaced in the nasopharynx

Case 2

A 5year old female patient presented to the emergency with foreign body in nose.

She had history of instrumentation done 1 day back. Multiple attempts of removal had failed due to non-cooperation of the patient, inferior turbinate hypertrophy and mucosal oedema. In order to avert more mucosal injury and to prevent the displacement of the foreign body in the airway, she was taken up for foreign body removal under general anaesthesia.

After securing the airway with endotracheal tube and with throat pack in situ, endoscopy was done which revealed a peanut at the level of middle turbinate and septum. It was removed in toto from the external nares. (Figure 3)

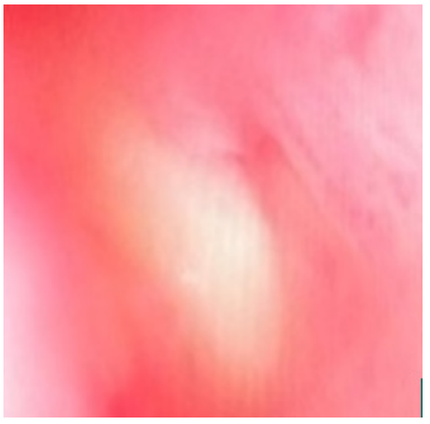


Figure 3: Showing the intra-op view of the peanut between the septum and the inferior turbinate,

Case 3 (Group 1)

Three paediatric cases presenting with esophageal coins were managed in our OPD. All the children were of the age group 3 to 5 years. Most of the coins were seen lodged at the level of cricopharynx, 15 cm from the upper incisors. They all needed esophagoscopic removal under general anaesthesia (Figure 4a, b). All the coins were successfully removed without any complications.

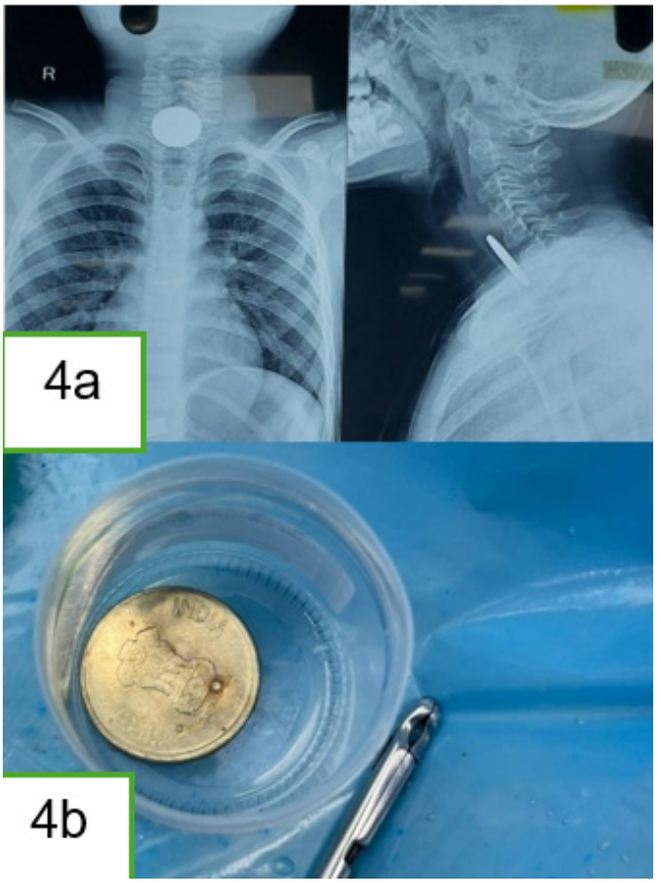


Figure 4: (a) Showing the preop Xray of the child with coin at the level of cricopharynx (b) coin after removal through the esophagoscope

Case 4 (Group 2)

A 36year old male presented to our emergency with history of difficulty in swallowing and odynophagia for 1 day. He had history of intake of chicken meal 1 day ago. He had symptoms of dysphagia, drooling of saliva and foreign body sensation in throat. Plain Xray revealed a chicken bone at the level of the cricopharynx. Esophagoscopy revealed a 7.5cm long bone fragment of a chicken bone which was lodged just below the cricopharynx. This foreign body was removed with no complications. (Figure 5a, b)

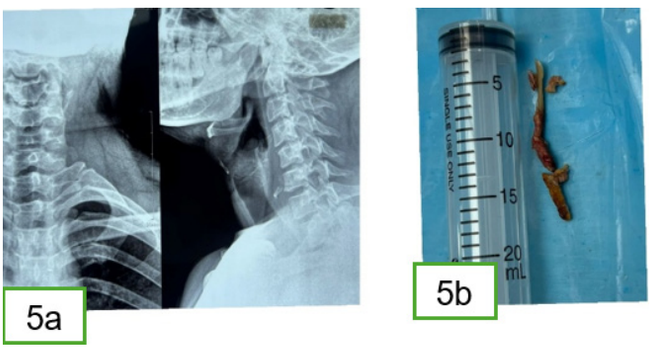


Figure 5: (a) showing the preop Xray of the throat showing the chicken bone. (b) 7.5cm long chicken bone piece removed.

Similarly, we had many cases of fish bone lodged at the tonsillar fossa and base of tongue which were successfully removed in the OPD. (Figure 6a, b)

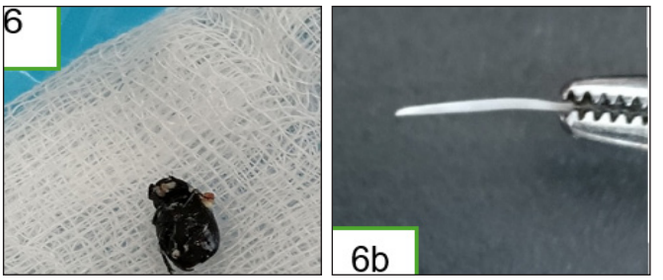


Figure 6: (a) showing foreign body insect removed from ear (b) showing the fish bone removed from tonsillar fossa

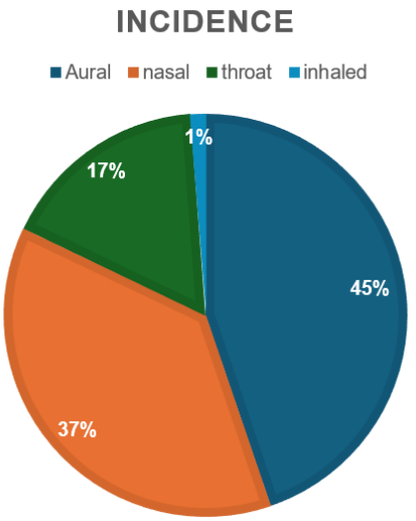
DISCUSSION

Children are at highest risk of foreign body emergencies mainly due to behavioural factors such as curiosity and imitation. Aural and nasal foreign bodies are more frequent but less complicated and hence, manageable in OPD settings. Foreign bodies of the airway and esophagus are more dangerous, almost always requiring GA and specialized procedures.[1-4] The factors associated with increased need for GA were small age group less than 5 years, vegetative foreign body and previous failed attempts at removal. Nevertheless, nasal foreign bodies must be dealt with cautiously due to increased risk of the foreign body going backwards during manipulation and getting aspirated in the airway of the crying child. Thereafter, they turn into foreign body of airway, posing a more life-threatening situation of airway compromise and lung collapse. The developmental activity of mouthing which is used by toddlers to explore things plays the most important factor in causing higher incidence amongst children. Other factors like boredom, psychological issues, availability of objects and lack of caregiver may also contribute in this incidence. Cases with predisposing ear problems like itching, pain, headache, discomfort led to increased incidence of probing the ear leading to impacted foreign body. Aural foreign bodies presented with otalgia, bleeding, fullness, otorrhea, tinnitus and hearing loss. Live insects were killed first by instilling olive oil so that the insect drowns in it and then removed by ear syringing. This is in accordance with the work done by Ansley et al in 1998 for ear foreign bodies.

The diagnosis of foreign bodies requires anterior rhinoscopy or otoscopic examination. Rigid nasal endoscopy also needs to be performed for some cases in whom the anterior rhinoscopy fails to visualise the foreign body. Instruments such as Jobson-Horne probe hook, Tiley's forceps and crocodile forceps are useful in their removal. Ring catheter or eustachian probe is used for removal of nasal foreign bodies Ear foreign bodies require syringing or suctioning.[2] Very rarely, if they get displaced into the middle ear after causing tympanic membrane perforation, do they require mastoid exploration under GA. Plain Xray of neck {both anterior posterior and lateral view} is a necessary

baseline investigation for all those with history of foreign body ingestion. Rigid nasopharyngoscopy and endoscopic laryngoscopy and upper gastrointestinal endoscopy need to be done for removal or at times when foreign body is not visible on Xray.

Mostafa et from Egypt noted the incidence of various types of foreign bodies as depicted in the Table 1.



In a study conducted by Barreto et al in 2005, they found that amongst the swallowed foreign bodies, fish bone was the most common followed by coin, then dentures and then meat bone. This is in contrast to our study where coin was the most common swallowed foreign body followed by fish bone, then chicken bone and lastly dentures. Hence the patient demographics vary with the local setting and age group.

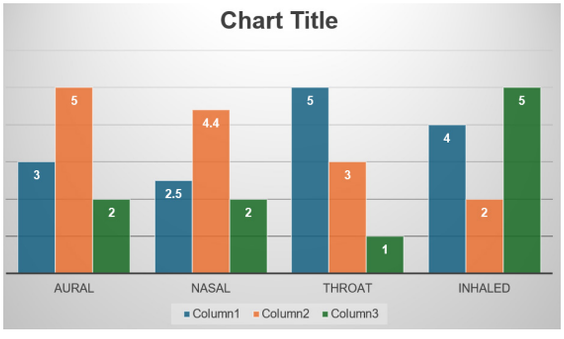
The types of foreign body at various sites in different institutes are summarised in the Table 2

In **aural** cases most common was beads (5) followed by insects (3) and then pins (2)

In **nasal** cases most common was peanuts (4) followed by stone (2) and 1 pin

In **throat** most common was coin (5) followed by fish bone (3) then chicken bone(1)

In **inhaled** cases, most of the cases were peanut (5) followed by beads (4) and then pins (2)



Here we are comparing the mean score obtained after dividing the prevalence of each type of foreign body in the area with the number of cases dealt with in different institutes.

Complications include esophageal perforation during esophagoscopy, nasal foreign body aspiration during anterior rhinoscopy, tympanic membrane perforation during ear foreign body removal and life-threatening airway compromise during bronchoscopy. Hence it is emphasized that there should be more skilful removal of foreign body in the first attempt itself, as repeated attempts increase complications.[1] Batteries, though inanimate, release chemicals which corrode the mucosa causing burns, necrosis, perforation, hence removal should be as quick as possible. Inhaled foreign bodies cause coughing, choking, decreased air entry. wheeze, cyanosis and crepitations. Hence, they warranty urgent removal under GA to prevent lung collapse and airway compromise. They require longer hospital stay and skilful removal by bronchoscope under general anaesthesia.

In our case series, all the foreign bodies were removed successfully with minimal complications.

CONCLUSION

Foreign bodies in ENT remain a common clinical problem in children. They may vary in shape, size and material. Symptoms may be ranging from asymptomatic to acute life threatening. Most cases are managed with simple maneouvres, but some cases involving esophagus and airway require operative intervention. Hence, a good first attempt by experienced hands is the best attempt to achieve better outcomes.

Strategies to curb the incidence includes parental education, early diagnosis and proper medical intervention. Hence, we recommend public health awareness regarding foreign bodies ingestion and their related consequences to all schools as well. The parents have to be made aware of the need for watchful supervision of the child's activities. They should keep the child safe from all small round bodies and sharp objects like pins. In case of an emergency they should not panic as it may worsen the situation. There should be no attempt to remove the foreign body at home. They should seek prompt medical care for better outcomes and child safety.

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