

Removal of unusual plastic paper foreign body from glottis of larynx - A Case Report

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Abstract

Introduction

Foreign body in glottis especially in infants is rare. Retrieval of foreign body is a rather simple procedure but sharing of the airway with the surgeon and impending complications makes it more challenging and dangerous. Most patients are younger than 4 years old In literature, incidence of foreign body of the larynx has been reported from 0.7% to 6.1% among all aero-digestive foreign bodies. Delay in diagnosis of the foreign body in airway has the potential to make a difficult situation even more serious.

Case Report

A 11 months female child, Wt 8.5 kg presented with complaint of not feeding and crying suddenly while eating biscuit one day back, followed by excessive Salivation, crying with difficulty in respiration and change in voice

Past history

not significant Birth history - FTVD at hospital, uneventful, normal development milestone Clinical examination - afebrile, conscious, drowsy, irritable. HR-140/min.; Chest - B/ L A/ E decreased. CVS - S1 S2 +, no added sound S

Investigation Hb

8.0 gm %, BT-3.05 sec.; CT - 4.10 sec.

Urine routine exam. - NAD. CXR-normal, CT Chest - not conclusive.

Patient was planned for diagnostic and therapeutic broncho scopy under GA. Anaesthetic Management - patient kept fasting for 6 hrs. Routine monitors attached. I/V line secured with 24 G intracath with RL. Preoxygenation done with 100% O2. Inj Glycopyrolate 5 µgm/kg iv, inj. Fentanyl 2µgm/kg iv given Induction done with sevoflurane and O2. Bag and mask ventilation was possible. Inj succinylcholine 2 mg/kg iv given. After 60 sec. laryngoscopy done for intubation. But a foreign body was seen at glottis covering it. Immediately ENT surgeon informed and they removed foreign body, a plastic paper with Magill forceps. After that broncho scopy done to check any other foreign body in trachea and bronchus. No other foreign body was found. Recovery and post operative period was uneventful.

Discussion

Foreign body larynx is not a common. Brkić, Lemberg, and Bitten court reported its incidence from 0.7% to 6.1% amongst all aero-digestive foreign bodies. It is prudent to diagnose aero-digestive foreign bodies as early

as possible to minimize potential life-threatening complications in particular glottic foreign body. However, in many cases it is not easy to make the diagnosis as classical symptoms of choking, wheezing and decreased breath sounds are absent and absence of conclusive radiological finding as in case of radiolucent foreign body like plastic paper. The delay in diagnosis is attributed to patient's behaviour or circumstances where aspiration was unwitnessed. Once the anaesthesia along with muscle relaxants is given, foreign body might fall down to sub glottis or trachea which is a more difficult area to deal with. General anesthesia is preferred for endoscopic removal of foreign body of the respiratory tract. The problems of full stomach and sharing of airway must be taken into account to maintain the airway for adequate ventilation and oxygenation in children.

Conclusion

Such unusual radiolucent foreign bodies of the respiratory tract can cause airway emergencies in children. Prompt diagnosis and bronchoscopic removal under general anesthesia with the aim to maintain adequate oxygenation and prevention of aspiration with rapid return of upper airway reflexes is the management. The vigilance, alertness and experience of the anesthesiologist could bring the patient's condition back to normal.

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