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"God in the Throat" An Unanticipated encounter

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ABSTRACT

Background:- A 48yr old female presented with sudden onset absolute dysphagia & aphoniasince 10 days with history of a psychiatric illness. X-ray neck showed a very large radio opaque object in cricopharynx & upper part of cervical oesophagus. Under short general anaesthesia,FB visualized with Mc intosch laryngoscope and removed with Magill forceps and was found to be an idol of Lord Balakrishna.To our knowledge, it is the first case being reported in the world literature of such a large and unusual foreign body.

Conclusion:- The authors state that such unusual foreign bodies should be anticipated in psychiatric patients who come with complains of sudden dysphagia, aphonia or respiratory distress.

Keywords: Foreign body, cricopharynx, psychiatric patient

I. INTRODUCTION

Foreign bodies (FBs) in the aerodigestive tract are important causes of morbidity and morality in the two extremes of life and pose diagnostic and therapeutic challenges [1]. The ingestion and aspiration of FBs occur most commonly inpediatric population, especially in their first six years of life [1–3]. However, they are not so uncommon in adults [4, 5]. Most FB ingestions in adults are related to eating, leading to either bone or meat bolus impaction, while poor dentition, inadequate chewing, and eating while being sedated can precipitate this problem [5, 6]. Food impaction may also indicate obstructive esophageal preexisting lesions such as esophageal (mucosal) ring, peptic or malignant esophageal stricture, or eosinophilic esophagitis [6, 7]. Adults account for only about 20% of the reported cases of aspirations [8]. In adults, it occurs more commonly in patients with psychiatric disorders, mental retardation, or impairment caused by alcohol, traumawith a decreased level of consciousness, and impaired airway reflexes, when airway protective mechanisms function inadequately or facial traumas. Various foreign bodies have been reported including dentures, coins, fish bone, chopstick [9] and even glass pieces in aero digestive tract.

II. CASE REPORT

A 48yr old female presented in our hospital with chief complaints of non-progressive absolute dysphagia & aphonia since 10 days which started suddenly to begin with. She could not swallow both solids and liquids and had signs of dehydration. As told by the patient's attender she was suffering from a psychiatric illness and was on irregular treatment. The patient was also repetitively pointing towards her throat. On examination oral cavity and oropharynx were normal. X-ray neck soft tissue showed a very large radio-opaque object in the cricopharynx & the upper part of cervical oesophagus. Routine blood investigations were sent on emergency basis and were normal. An emergency tracheostomy was anticipated and all the necessary arrangements were made. Before shifting to OT patient was given IV Ringer lactate 750ml as she was dehydrated. Before giving anaesthesia, 100% Oxygen was given for 3 min. Later she was premedicated(Glycopyrollate 0.05mg/kg, Fentanyl 2 micro-gm/kg, Midazolam 0.05mg/kg) and sedative dose of Propofol (1mg/kg) was given slow intravenous. FB removal was anticipated under direct laryngoscopy but while putting blades of Macintosh laryngoscope metallic article was seen and using Magill forceps it was removed a-traumatically and in toto and to everyone surprise it was found to be an idol of Lord Balakrishna (measuring 5.2cmx4cm). There were no apparent mucosal tears or lesion seen. Post op period was uneventful and vitals were monitored regularly. A course of IV antibiotics, anti-inflammatory and steroids were given for a week and was evaluated by a psychiatrist and later the patient was discharged. Patient came for regular follow up and after 2 months video-laryngoscopy and upper GI-scopy was done and no lesions were found. To our knowledge, this is the first case being reported in the world literature of such a large and unusual foreign body.

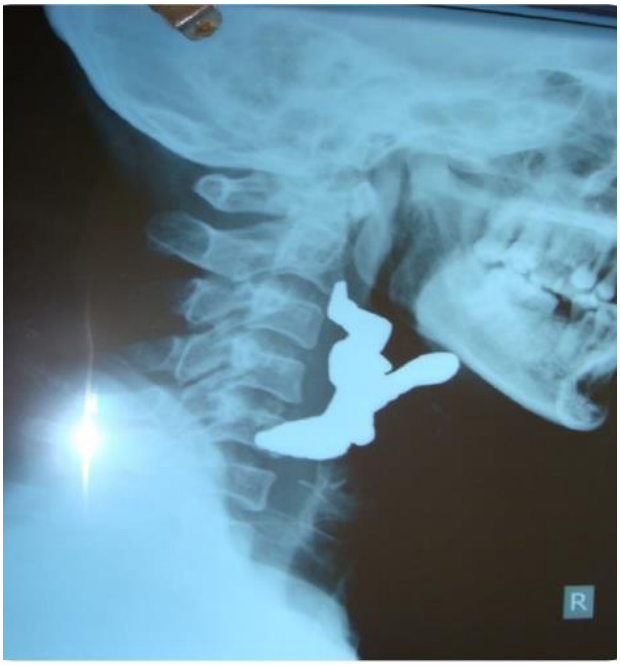

Fig A. X-Ray Neck showing F.B.

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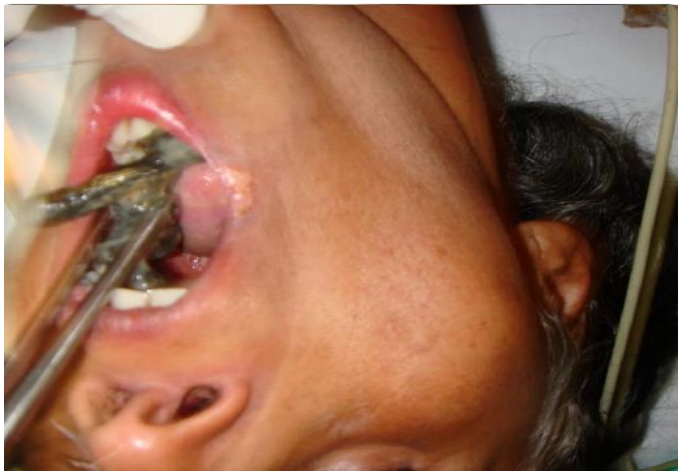

Fig B. Intra op picture

Fig C. F.B. (5.2x4cm)

III. DISCUSSION

Foreign body impaction in the upper airway and digestive tract has been a problem since the earliest of reported history. The foreign body spectrum was defined by Jackson as an object or substance foreign to the location where it is found [10]. He classified them as exogenous and endogenous. An infinite variety of foreign bodies may be inhaled or swallowed. A foreign body lodged in the cricopharynx can cause damage/obstruction to the airway. Groundnut, castor seed, pieces of brick, stones, earrings, pins and whistles are some of the common foreign bodies aspirated into the airway whilst fish bone(44.6%), mutton piece, chicken bone(13.3%), coins(33.2%)[11] are the common foreign bodies swallowed into the food passage. Nearly 90% of swallowed objects traverse the gut uneventfully in less than 7 days. Carelessness of parents (in case of children), poor vision, mental infirmity, drug addiction and rapid eating are some of the factors responsible for this. However, most foreign body ingestion occurs in children between 6 month and 6 years of age; the rate of foreign body ingestion in adults is lower. Dentures, chopsticks and even glass pieces have also been incriminated in the literature. Self-inserted or ingested foreign bodies are quite common in the paediatric age group. In adults, self-inserted foreign bodies in the skull, orbit, sphenoid sinus, urethra and abdomen [12-18] as well as intentional ingestion of foreign bodies have been reported. The severity of the symptoms depends upon the site, size, composition and period for which the foreign body has been present. It can be life threatening thus needing prompt management. Early removal of the foreign body is necessary if stuck in the cricopharyngeal sphincter or esophagus, by general anaesthesia. Hospital stay and morbidity can be decreased, only if treated as early as possible. Case descriptions of both types of foreign body aspiration are abundant and in general the presumptive diagnosis is readily apparent and management carried out accordingly. Thus in cases of oesophageal foreign body, the clinical presentation is usually with acute dysphagia, choking, gagging, drooling and regurgitation. Diagnosis at times becomes difficult because of the non-availability of a clear history, as in our case where due to psychiatric illness patient swallowed such a huge foreign body. In these cases, the importance of a psychiatric evaluation is stressed and this applies similarly to our patient. Any self-inserted foreign body must be evaluated in the context of a potential psychiatric illness and the patient described here did indeed have a psychiatric history. The history of foreign body ingestion in such patients is rarely forthcoming so the index of clinical suspicion should be high. Ingestion of such a big idol is dangerous as it can cause perforation due to its sheer size and pointed edges. Caretakers of these patients should be alert to the possibility of foreign body ingestion. Foreign body removal is associated with a high degree of risk; a skilled surgeon is needed to perform a preoperative assessment and develop a good treatment plan. A multidisciplinary team is required including the ENT surgeon, anaesthetist, and psychiatrist to deal with such cases. We believe that removal of foreign bodies is best done in the operating room. In this case, because while using Macintosh laryngoscope we could visualize the foreign body outside, we removed it. To date, the case in the present report is the first clinical report of such an unusual and large foreign body. To our knowledge, this is the first clinical report of this type of retrieval in a single case.

IV. CONCLUSION

Foreign bodies of aero digestive tract are ENT emergencies and should be removed urgently. The author wants to specially emphasize that patients with psychiatric history should be evaluated thoroughly, especially when there is history of dysphagia, aphonia or respiratory distress. Aspiration or ingestion is usually not observed by caretakers in such cases.

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Diagnosis requires a high index of clinical suspicion and unusual foreign bodies can be expected.

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