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Metallic Foreign Body in the Oropharynx of an Eight Year Old Child

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Abstract

Foreign bodies of the oropharynx are a common occurrence in children. Their clinical diagnosis and therapeutic management depend on the extent of the lesions, the nature and the path of the metallicforeign body. We report a case of a metallic foreign body penetrating the oropharynx, in an 8-year-old boy, following oropharyn geal trauma. Clinical examination revealed a metallic body, pointedwith a hooked end, 32 cm long, corresponding to a meat or fishskewer. The foreign body was removed endobucally under general anaesthesia.

Keywords: *child, metallicforeign body, oropharynx, extraction, evolution.*

Introduction

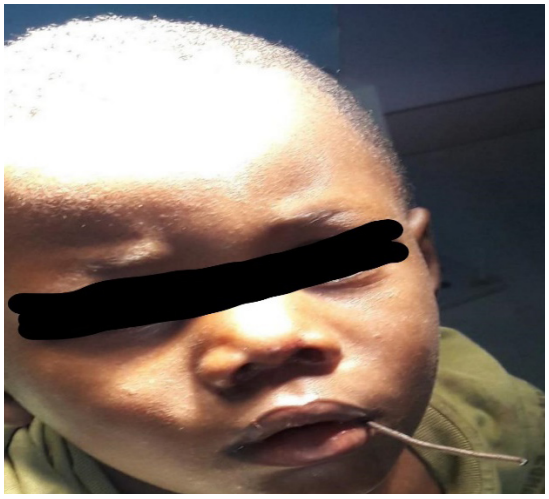
Penetrating foreign bodies of the oropharynx are relatively common emergencies in children. The clinical and prognostic severity depends on the nature of the foreign body, the location and the violence of the trauma. The foreign body is some times responsible for serious or even life-threatening complications [1, 2, 3, 4]. Diagnosis is usually easy, but can bedifficult in the case of an unrecognised foreign body or one that is deep in the body. Extraction is often performed endo-buccally under general anaesthesia. [5, 6, 7,8].

Over a period of fifteen years of professional activity, we report a case of a metallic foreign body of the oropharynx in a child, whose interest lies in the clinical examination, the nature of the vulnating agent and the extraction technique.

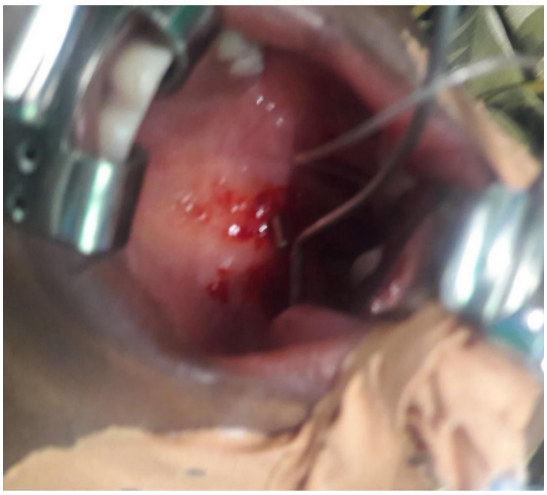
Case report

The child Pa...Yo, 8 yearsold, male, was admitted in emergency on 10 June 2015 for dysphagia and emission of bloody sputum, following a trauma by a metal object during a game. Indeed, the child was running with his metal object in his mouth, and when he fellit cause doropharyngeal trauma by a foreign body penetrating the oropharynx *(Figure 1)*.

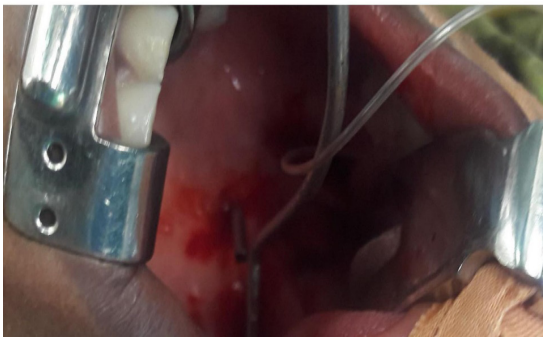
The examination on arrivalnoted a disturbed child, withcrying and sweating. The lesion assessment showed the foreign body strangling the uvula in a ring with a 2 cm linearwound on the right tonsilpillar *(Figure 2).* This assessment was completed in the operating room under general anaesthesia with orotracheal intubation, allowing the presence of the metallicforeign body planted in the right velotonsillarregion *(Figure 3).*, forming a knot on the uvula, with a 2 cm linearwound on the right velotonsillar, the surgical management consisted of the disinsertion - extraction of the foreign body around the uvula with out mucosallesion, followed by a trimming of the woundwithvicryl 3/0. The extracted foreign body wasmetallic in nature, 26 cm long, with a hooked tip *(figure 4)*. The surrounding mucosa of the oropharynx was oedematous and inflammatory. The surgical management was completed by antibiotic therapy coupled with analge sick treatment and anti-tetanussero vaccination. The postoperative course was simple with a diet of soup and porridge.



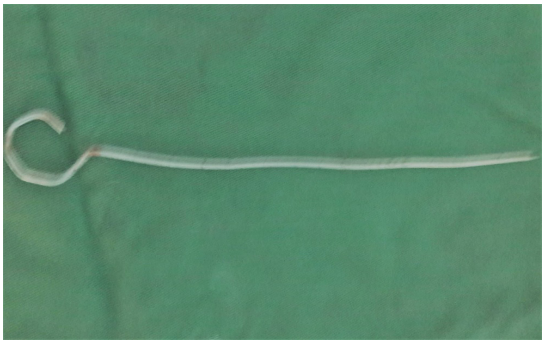
Microphotograph1. *Child 8 yearsold_ metallicforeignbody_externalized part exobuccal*



Microphotograph2. *Uvula plugging by the hooked end of the metallicforeign body*



Microphotograph3. *Skewering of the uvula through the hooked end of the intraoperativeforeign body*



Microphotograph4. *Foreign body extractedwithhooked tip*

Discussion

Penetrating foreign body injuries of the oropharynx in children are relativelycommon, but their incidence is not wellknown [1,2]. In the literature, the averageage of oropharyngeal trauma isbetween 4 and 5 yearswith a slight male predominance [4, 9, 10, 11, 12].

The circumstances of occurrence of penetrating oropharyn geal foreign bodies are most often obvious, classically, children run withobjects in theirmouth, mayfall and suffer an oropharyngeal trauma or a penetrating oropharyn geal foreign body [5]:thisis the classicpencil injuries of the Anglo-Saxons [6].

The nature and location of the foreign body vary [9, 10, 11]. SOOD et al reported a case similar to ours where a 13cm long pointed metallic foreign body was embedded in the oropharynx of an 8 yearoldchild [3]. MISHRA et al reported a rustymetalforeign body 8 cm long that penetrated the left retro auricularregion of a 25 yearold patient [6]. BURDUK et al reported an unusual case of a toothbrush-like foreign body in the parapharyngealspace of an 18-month-old infant [5]. In our case, the metallicforeign body was 32 cm long, with a hooked end, resulting in a 2 cm woundwith a notch on the uvula. The length, the path and the lesions caused by the metallic body make our clinical observation an exceptional case.

The clinical diagnosis of a foreign body in the oropharynx iseasy, as itis made following a good initial clinical examination [8]. Indeed, the question in greveals a symptom atology dominated by dysphagia, odynophagia, hyper sial orrhoea, haemorrhage or sometimes subcutaneous emphysema in case of deep oropharyn geal wound [1, 2, 6]. In our case, the clinical examination perform edintra operatively and under general anaesthesia was of great diagnostic value.

In the therapeutic approach, the desinsertion - extraction of foreign bodies obeys the apophthegm

of Chevalier Jackson, «anyforeign body of the upper aero digestive tract which has penetrated through the natural tract may be extracted through the same tract provided thatit has not migrated through the perforated wall of the tract»; Indeed, our attitude and our surgical procedure met this approach; for weperformed a disinsertion - extraction of the hooked metal tip that encircled the uvula, followed by a trimming of the 2 cm linearwound of the right tonsil piler.

According to the majority of authors, antibiotictherapy and anti-tetanussero-vaccination are systematic [8] in order to avoid the occurrence of infectious complications (para or retro pharyngealabscesses), cervico-facial cellulitis, mediastinitis, tetanus), which are often life threatening. Foreign bodies migrating into the parapharyngeal space are dangerous because of possible damage to the internal carotidartery or vagus nerve.

Conclusion

Metal foreign body injuries of the oropharynx in children require careful clinical examination to determine the lesionstatus, nature and pathway of the foreign body. Symptom atologyis often variable, and the therapeutic decision depends on the state and extent of associated lesions. Disinsertion - extraction is the most commonly used procedure, coupled with trimming in the case of a wound, antibiotic prophylaxis, analgesic treatment and anti-tetanussero therapy.

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