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Pancreatic Disorders & Therapy

Case Report

Sometimes the Simplest Solution is the Best One: Unconventional Resolution of a Food Impaction

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ABSTRACT

The most common type of esophageal impaction is those which are caused by ingested food. These impactions can pass spontaneously, or when it's necessary by the use of endoscopic intervention(s). Another alternative when endoscopy fails in intravenous administration of glucagon, which has a varying level of success. We present a case that demonstrates that not all food impactions behave the same, and that medical technology/sophistication is not always the answer. In our scenario, upper endoscopy was the procedure of choice to remove an impacted fish bone, but this was ended up being ineffective.

Keywords: Esophageal impactions; Endoscopic intervention; Food impactions; Foreign body ingestions

INTRODUCTION

Impacted food particles/foreign bodies create urgent but not life-threatening clinical scenarios; the provided airway is not compromised. Early Gastroenterology consult plays a crucial role in management. Foreign body ingestions are accidental in 95% of cases and are always related to the intake of food (e.g. swallowing of fish/chicken bones, toothpicks) [1].

Almost 90% of ingested foreign bodies will pass spontaneously, though a small portion will require endoscopic interventions [2-5]. The esophagus is the most common site for impaction, though, as in this case, foreign bodies in the base of the tongue have been reported [6]. The esophagus is a muscular tube that conveys food and fluids from our mouth to the stomach. We may not know about our esophagus until swallowing something excessively enormous, excessively hot, or excessively cold. At that time we may likewise see it when something isn't right. It might feel torment or have an inconvenience swallowing. The most normal issue with the throat is GERD (Gastro Esophageal Reflux Infection). With GERD, a muscle towards the finish of the esophagus doesn't close as expected. This permits stomach to move the substance to reflux, into the easophagus and disturb it. GERD can cause harm to the esophagus. Other issues incorporate an indigestion, disease, and eosinophilic esophagitis. Specialists might utilize different tests to make a conclusion. These incorporates are imaging tests, an upper endoscopy, and a biopsy. Treatment relies upon the issue.

A few issues get better with over-the-counter medications or changes in diet. Others might require physician recommended meds or medical procedure. A Lower Esophageal Sphincter (LES) permits acidic stomach substance to back up (reflux) into the throat. Reflux can cause indigestion or raspiness, or no side effects by any means. Esophagitis can be happen because of inflammation (as from reflux or radiation therapy) or contamination. Normal reflux of stomach corrosive bothers the esophagus, which might cause the lower part to change its construction. Disintegration in a space of the coating of esophagus this is frequently caused by ongoing reflux. In individuals with cirrhosis, veins in the throat might become engorged and swell. These veins are defenseless against hazardous dying.

Clinical presentation in the impacted patient varies from acute onset of dysphagia to near-choking, hyper salivation and refusal to eat. Frank blood or blood-staining in expectorated material/saliva can indicate perforation. Drooling is the most common manifestation of esophageal obstruction [7-9]. Complications are described in the literature include perforation, obstruction, and aorto-esophageal or tracheo-esophageal fistula formation [10-13]. Flexible endoscopy is the procedure of choice in the treatment of resistant esophageal food impactions and it is preferably done

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Received: 11-Mar-2022; Manuscript No. PDT-22-16215; **Editor assigned:** 14-Mar-2022; Pre QC. No. PDT-22-16215(PQ); **Reviewed:** 28-Mar-2022; QC. No. PDT-22-16215; **Revised:** 25-Apr-2022; Manuscript No. PDT-22-16215 (R); **Published:** 02-May-2022, DOI: 10.352481/2165-7092.22.12.232.

Citation: Elfituri A, Ortiz I, Bukeirat F (2022) Sometimes the Simplest Solution is the Best One: Unconventional Resolution of a Food Impaction. Pancreat Disord Ther. 12: 232.

within 24 hours of diagnosis to avoid the development of significant complications [14,15].

CASE PRESENTATION

A 55 year-old female presented to the Emergency Department (ED) with throat pain, from starting she felt a bone lodged in her throat while eating a meal of catfish. Her medical status was remarkable only for well-controlled hypertension. She subjectively felt the bone "stuck in her throat" and denied any fever, chest pain or shortness of breath. In the ED, vital signs were stable, and physical examination was unremarkable. Radiography of the head and neck showed no discrete radio-opaque foreign body identified, while a head/neck CT scan revealed a 1.3 cm hypo-density along the rightward oropharynx, extending into the right lingual tonsil and foreign body impaction was confirmed and the gastroenterology team was consulted.

RESULTS AND DISCUSSION

Esophagogastroduodenoscopy (EGD) was performed, revealed a normal esophagus. The z-line was regular and was found 39 cm from the incisors; the stomach and duodenum were normal in appearance. There was an approximately 1 cm fish bone lodged in the base of the tongue/distal oropharynx on right side (Figure 1). Two attempts at removal by using cold-biopsy forceps were unsuccessful. After the second attempt was made, the procedure was paused in order to suction and secretions from the patient. Then, a third pass with the endoscope revealed, the bone fragment was no longer present, but it could not be visualized within the scope itself, nor anywhere in the patient's mouth/GI tract. Inspection of the Yankauer's suction the device was revealed the fish bone it had indeed been retrieved and it had wedged almost perfectly perpendicularly within its distal aperture (Figure 2), in such a way that it was prevented from being pulled into the attached plastic tubing by the wall suction (Figure 3). The patient recovered easily from the procedure, had a regular diet resumed and was discharged the same day.

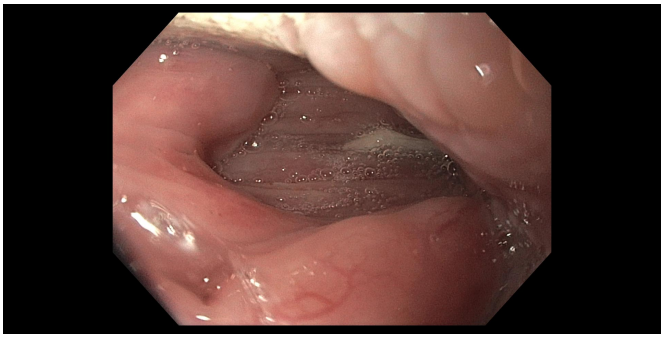

Figure 1: There was an approximately 1 cm of fish bone which was lodged in the base of the tongue/distal oropharynx on right side.

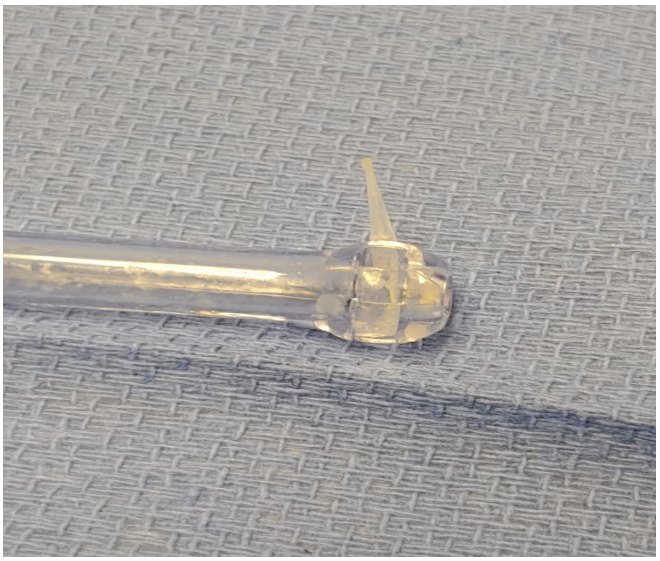

Figure 2: The Inspection of the Yankauer's suction device is revealed the fish bone had indeed been retrieved and had wedged almost perfectly perpendicularly within its distal aperture.

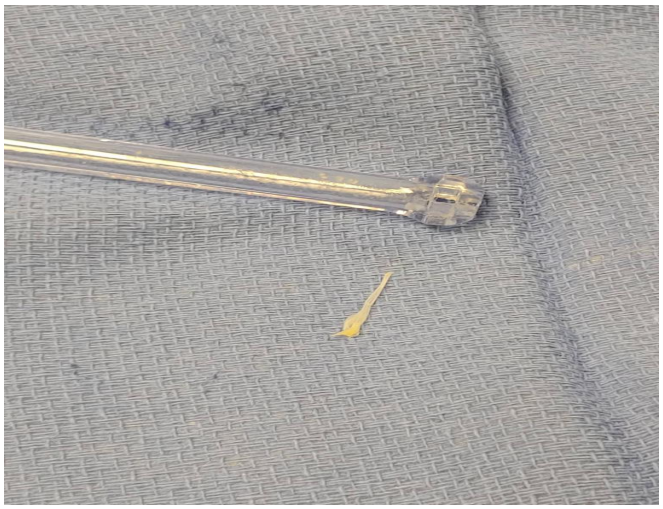

Figure 3: It has been shown such a way that it was prevented from being pulled into the attached plastic tubing by the wall suction.

The esophagus is the far most frequent site of obstruction in the GI tract. Ingested foreign bodies are often impacted at the sites of physiological or pathological luminal narrowing, as in this case, where a catfish bone was lodged at base of the tongue. This location was proximal to the esophageal inlet, and was poorly conducive to retrieval by endoscopy. However, the offending item turned out to be highly amenable to retrieval through a more "low-tech" approach, i.e. blind or pharyngeal suctioning.

CONCLUSION

When approaching these cases, the history should always include the type of foreign body, the time of ingestion and the type of symptoms. Early gastroenterology consult is mandatory and urgent. Endoscopy should not be delayed (even in the absence of imaging). When necessary, removal should be accomplished within 24 hours, as the risk of complications dramatically increases with time. Finally, as we have seen in this scenario, the classic endoscopic interventional approach attempting to either "push down, retrieve or morcellate" is neither always effective nor necessary.

REFERENCES

1. Pellerin D, Fortier-Beaulieu M, Guegen J. The fate of swallowed foreign bodies: Experience of 1250 instances of subdiaphragmatic foreign bodies in children. Program Pediatr Radiol. 1969; 2:302.
2. Carp L. Foreign bodies in the intestine. Ann Surg. 1927; 85:575.
3. Birk M, Bauerfeind P, Deprez PH. Removal of foreign bodies in the upper gastrointestinal tract in adults: European Society of Gastrointestinal Endoscopy (ESGE) Clinical Guideline. Endoscopy. 2016; 48:489.
4. Weiland ST, Schurr MJ. Conservative management of ingested foreign bodies. J Gastrointest Surg. 2002; 6:496.
5. Wu WT, Chiu CT, Kuo CJ. Endoscopic management of suspected esophageal foreign body in adults. Dis Esophagus. 2011; 24:131.
6. Li ZS, Sun ZX, Zou DW. Endoscopic management of foreign bodies in the upper-GI tract: Experience with 1088 cases in China. Gastrointest Endosc. 2006; 64:485.
7. Ikenberry SO, Jue TL. Management of ingested foreign bodies and food impactions ASGE: Standards of Practice Committee. Gastrointest Endosc. 2011; 73:1085.
8. Nandi P, Ong GB. Foreign body in the oesophagus: Review of 2394 cases. Br J Surg. 1978; 65:5.
9. Khan MA, Hameed A, Choudhry AJ. Management of foreign bodies in the esophagus. J Coll Physicians Surg Pak. 2004; 14:218.
10. Zhang X, Liu J, Li J. Diagnosis and treatment of 32 cases with aortoesophageal fistula due to esophageal foreign body. Laryngoscope. 2011; 121:267.
11. Ahn D, Heo SJ, Park JH, Sohn JH. Tracheoesophageal fistula with tracheal stenosis resulting from retained esophageal foreign body. Auris Nasus Larynx. 2011; 38:753.
12. Sung SH, Jeon SW, Son HS. Factors predictive of risk for complications in patients with esophageal foreign bodies. Dig Liver Dis. 2011; 43:632.
13. Tonkic A, Kulic D, Peric M. Bacteremia caused by a swallowed toothpick impacted in the gastric mucosa. Case Rep Gastroenterol. 2011; 5:227.
14. Webb WA. Management of foreign bodies of the upper gastrointestinal tract: update. Gastrointest Endosc. 1995; 41:39.
15. Li ZS, Sun ZX, Zou DW. Endoscopic management of foreign bodies in the upper-GI tract: Experience with 1088 cases in China. Gastrointest Endosc. 2006; 64:485.