



Case Series

UNUSUAL PRESENTATIONS OF FISH BONE FOREIGN BODIES: A CASE SERIES

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ABSTRACT

Accidental fish bone ingestion is common among fish consumers. In most instances, the patient recalls the history of consuming fish meal. However, the history is doubtful if fish is consumed on a daily basis. The most common and predictable sites of impacted fish bone are the palatine tonsils, the base of tongue, the vallecula and pyriform sinuses. A case of fish bone ingestion becomes challenging when fish bone gets impacted in an unusual site. We report four cases of fish bone impaction which posed diagnostic and management challenges because of their unusual presentation.

Keywords: fish bone, migrating fish bone, fish bone thyroid, foreign body

INTRODUCTION

Accidental ingestion and impaction of fish bone is very common among fish consuming communities. Fish bone impaction presents as a pricking sensation in the throat and occasionally dysphagia if associated with infection. In most cases, patients give a history of consumption of fish meal. In the Meitei community of North –East India, fermented fish is a part of everyday cuisine used as a foundational flavouring agent. In such communities, there can be fish bone impaction with a solid positive history. Patient based symptomatic localization is not accurate in most cases.^[1] About 80% to 90% of foreign body fish bone are passed down spontaneously.^[2] The most common site of fish bone impaction are the palatine tonsils, base of tongue, vallecula.^[3,4] Rarely a large fish bone can get impacted in the cricopharynx.

Diagnosing a fish bone impaction can be challenging when the history is doubtful, in case of unusual location of the fish bone.

Case 1: A 8 year old boy presented with complaints of painful swallowing and neck swelling since the past 3 days. He also gave a doubtful history of fish bone ingestion.

On examination, there was an enlarged thyroid gland on the right side which was tender on palpation.

X-Ray soft tissue neck was ordered to rule out fish bone impaction the aero-digestive track. No foreign body was visible in X-ray soft tissue neck and possibility of foreign body impaction was ruled out. The patient was sent home with a three day course of NSAIDS considering acute thyroiditis as a differential diagnosis for painful thyroid swelling. The patient reviewed after 3 days with improvement in pain and no decrease in size of the thyroid swelling. Ultrasound neck was advised and FNAC if required.

On ultrasonography, foreign body was visualized in thyroid parenchyma. The location of the foreign body was further confirmed by a computed tomography scan.

Neck exploration was done and fish bone was retrieved from the trachea-oesophageal groove still piercing the oesophageal musculature. Thyroid gland was preserved and no further complications were observed and the patient was discharged next post operative day.

Case 2

A 38 years old female presented with pain in neck and dysphagia for the past 2 days. The patient gave a doubtful history of fish bone ingestion 2 days back. The patient consulted a private clinician and underwent flexible fiberoptic endoscopy on his advice. Foreign body was visualized and an attempt

was made to retrieve the foreign body. While attempting, foreign body migrated extraluminal and the patient was referred to our hospital for further management. We advised a computed tomography scan foreign body was visualized outside the lumen and in the neck musculature.

First, rigid oesophagoscopy was done to rule out any intraluminal foreign body. After ruling out, neck exploration was done. The trachea-oesophageal groove was exposed. Foreign body was not visible even after a good exposure. With the help of C-arm, real time location of the foreign body was traced. After a failure of searching in the neck, rigid oesophagoscopy was done and foreign body was visualized inside the lumen piercing the wall and was removed. The patient developed no complications and was discharged the next day.

Case 3

A 29 year male presented with complaints of hemoptysis and a pricking sensation in throat for the past two days. There was no history of fever or prolonged cough. He gave a history of one bout of cough during the meal.

Routine laryngoscopy examination was done to rule out any oropharyngeal and laryngeal cause of hemoptysis.

Laryngeal endoscopy revealed a small fish bone over the posterior one third of the vocal cord. Foreign body was removed under general anaesthesia and the patient was sent home on oral antibiotics.

Case 4

A 27 year old male presented with a history of fish bone ingestion just one hour prior to presentation. The patient complained of foreign body sensation in throat while swallowing. Routine laryngeal endoscopy was done and fish bone was searched in all the common sites of fish bone impaction. Finally after tilting the endoscope upward, a part of the fish bone was seen in the nasopharynx. fish bone was retrieved from the nasopharynx transnasally.



Figure 1: Thyroid swelling on left side



Figure 2: Foreign body embedded in left thyroid lobe



Figure 3: Foreign body seen in neck placed obliquely

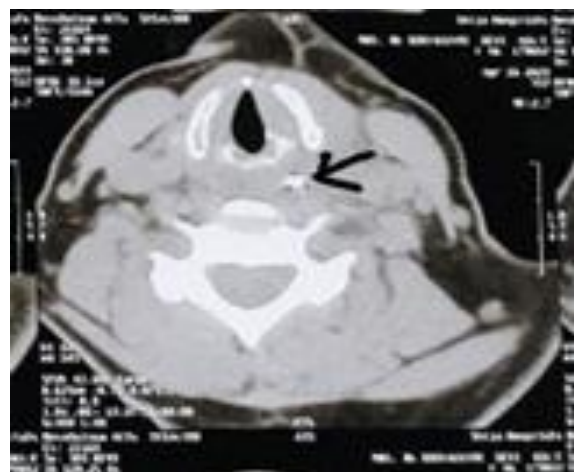


Figure 4: Foreign body seen embedded in the soft tissue of neck



Figure 5: Foreign body seen as an ulcer over left vocal cord

DISCUSSION

Unusual presentation of a fish bone foreign body may pose a diagnostic challenge. The diagnostic tools available to diagnose and localize a foreign body fish bone are fiberoptic endoscopy, X-ray soft tissue neck, ultrasonography and computed tomography scan. Fish bone lodged in palatine tonsils can be visualized and removed on routine headlight examination. Endoscopy is both diagnostic as well as therapeutic. X-Ray soft tissue neck is generally used in emergency rooms or in peripheral hospitals for screening. The detection rate of plain radiography for fish bone foreign bodies ranges from 23.5% to 54.8%.^[5,6] Ultrasonography is another diagnostic tool. It is easily accessible, portable and images are viewed in real time. Computed tomography scan can provide more information and has a sensitivity and specificity of 75% and 100% respectively.^[7]

Following a fish bone impaction, an attempt is made to push the fish bone down into the digestive tract by ingesting a food bolus. Additionally if the foreign body is in the proximal oropharynx like tonsil, digital manipulation is often done. These manipulations put the fish bone at the risk of extraluminal migration. Fish bones that penetrate the cervical oesophagus and migrate into the thyroid glands or lateral neck spaces are relatively large, sharp and stiff.^[10] The average time from ingestion to presentation varies from a few hours to 9 months because of patient factors and diagnostic dilemma.^[10]

The incidence of fish bone impaction in the larynx is 4.2%.^[9] Fish bone in nasopharynx has not been reported so far. Fish bones in these sites are usually associated with a history of coughing during ingestion.

Complications following fish bone ingestion such as perforation and abscess formation occur in approximately 12-18% of cases.^[2,3,4,8] Luckily none of our patients developed any complications.

Neck exploration and removal externally remains the mainstay of treatment for migrated foreign body in neck.^[8,11]

Migration of fish bone or location in an unusual site should be suspected if there is persistent or worsening of symptoms in patients with a positive history and a negative endoscopic findings.^[11] Misdiagnosis and delayed treatment should be avoided at all cost.

CONCLUSION

Fish bone foreign body in aero-digestive tract is a common entity. Yet, some presentations can be rare and pose a diagnostic dilemma and delay management. Persistent or worsening of symptoms despite a negative clinical examination must warrant a surgeon to consider a differential of extraluminal migration. Localization of foreign bodies followed by removal are utmost important.

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