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Gagging, choking, vomiting and refractory wheezes are classic signs that children may have ingested foreign bodies.

Foreign body ingestion in children

Children often present at the emergency department having ingested foreign bodies (Foley, 2006). They commonly present aged between six months and four years. At this stage of their development, they are starting to explore their surroundings, which means they can put foreign bodies into their mouths and swallow them (Paul et al, 2010).

Foreign bodies can be items such as coins, pins, safety pins, screws, nails, toy parts, and food items such as fish bones. Batteries and magnets are particularly problematic foreign bodies (Paul et al, 2010). Not all foreign bodies are visible on X-ray, for example plastic toys and some bones. It is important that children with a history of foreign body ingestion are treated clinically.

Reports have suggested that 40% of the foreign body ingestion in children goes unnoticed and 50% of children with a confirmed ingestion remain asymptomatic (Paul et al, 2010). Common symptoms of foreign body ingestion may include:

- Gagging;
- Choking;
- Drooling of saliva;
- Retching;
- Vomiting;
- Behavioural disturbances;
- Refractory wheeze (Paul et al, 2010; Foley, 2006).

Often these foreign bodies are passed spontaneously (Foley, 2006). Sometimes their detection may be incidental – children may present to the emergency department with different complaints but show signs of having ingested a foreign body (Melissa et al, 2010).

Children presenting with a sudden respiratory compromise, particularly those who are wheezing, should not only be assessed for asthma but may also have inhaled or ingested a foreign body. Penetrating foreign bodies of the oropharynx are encountered in children of all ages but frequently seen in those between the ages of three to five years. This age group has a higher risk of airway compromise and needs special consideration in terms of managing the airway (Incollingo and Shevchenko, 2007).

Clinical presentation and initial management

A previously healthy two-year old boy presented with a history of having ingested a window key. There was no history of choking, coughing or vomiting. The parents brought him to the emergency department so that he could be checked over.

Initial observations were reported to be within normal limits. On examination the boy was found to be well, alert and playful. The abdominal examination did not reveal any tenderness and bowel sounds were audible. An abdominal X-ray was performed, which confirmed the presence of the key in the gut (Fig 1); he was under observation in the department for two hours.

As the boy was clinically well with no signs of obstruction, such as bilious (green) vomiting or abdominal distension, and the foreign body was seen to have passed through the oesophagus, it was decided to conservatively manage him with a “wait-and-watch” approach.

Progress

As he remained well for the next few hours, the boy was discharged home. His parents were advised to monitor the faeces for the key, and to bring him back to the emergency department should they notice any symptoms or deterioration in his condition. The key was defecated a day later and he has remained well. At discharge, the nursing staff advised the parents on accident prevention; the family was later reviewed by health visitors with regard to home-safety issues.

Conclusion

This case shows how important it is to be aware of a common presentation in children and the red flags that need to be considered. Children may not report about the ingestion and it may go unnoticed by their parents. The risk that the foreign body may get lodged in the oesophagus always exists and early surgical intervention is necessary to remove the foreign body. Nurses play a vital role in advising parents on how to prevent future ingestions.

References

Foley D (2006) Need for endoscopic removal of oesophageal coins in children was similar for strategies of immediate removal and watchful waiting. Evidence Based Nursing; 9: 2, 42.

