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Migration of Hypo Pharyngeal Foreign Body to Para Pharyngeal Space

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ABSTRACT

Migration of foreign body from Hypo pharynx to Para pharyngeal space is rare. Foreign bodies of pharynx, oesophagus, larynx, trachea and bronchus are commonly found in otolaryngology practice. Migration of the foreign body from the hypopharynx to the neck is also found. Fish bones are the most commonly ingested foreign body. | Here we are presenting a case of 50 year old male with history of chicken bone ingestion since 3 days. Patient came to us with history of throat pain and swelling in the left lateral side of the neck. With preliminary investigations like X-ray neck and direct laryngoscopy we could not detect the foreign body. CT scan was ultimately done to detect the foreign body and the Para pharyngeal abscess on left side. | It was removed with external approach with the C arm imaging guidance. | We are presenting this case for its rare occurrence. |

Introduction

Foreign bodies of pharynx, oesophagus, larynx, trachea and bronchus are commonly found in otolaryngology practice. Sometimes these foreign bodies can pierce the wall of these structures and may lay extraluminally either in the wall of these structures or in the soft tissues of neck [1, 2].

Migration of the foreign body from the hypopharynx to the neck is also found. Fish bones are the most commonly ingested foreign body. They have a tendency to stick in the pharynx and the mucosal layer of the gastrointestinal tract due to their linear shape and sharp edges and can cause serious complications if left untreated. In most of the cases fish bone can be removed safely by endoscopy. But they may migrate extraluminally to the skin in rare cases.

In our case patient has a history of chicken bone ingestion and manipulation by finger. It could not be located by direct laryngoscopy. C –arm was useful in locating it in our case. It was removed by external approach in the neck.

Case Report

A 50 year male patient came to our out patient department of R.R ENT Specialty Hospital, with history of pain in the throat and difficulty in swallowing since 3 days. He developed a swelling in the left side of the neck since 2 days. Fever and body ache since 1 day. On taking history we came to know that he had ingested chicken bone 3 days back after that he started pain. For that he has taken some local treatment but not relieved. He had manipulated the area in the throat with his finger to remove the foreign body. After that pain subsided and a swelling developed in the left side of the neck on the next day. He developed fever since one day which was low grade associated with bode ache and not associated with chill and rigor.

On examination patient was having toxic face and febrile. His pulse rate was 110/min, B.P was 130/88 mm of Hg, temperature was 100^{o} F and respiratory rate was 20/min. On examination of neck there is a swelling of size 2cm X 2cm on left side just lateral to the lower border of thyroid cartilage. On palpation the mass was firm in consistency cystic and tender. There was local rise of the temperature. We could not detect foreign body by X-ray neck antero-posterior and lateral view. Fine needle aspiration cytology of the lesion was inconclusive showing only inflammatory cells and pus cells.

We did CT scan neck axial, coronal and sagittal section to identify the migration of foreign body in the neck. CT scan detected a linear hyper dense foreign body in the left Para pharyngeal space at the level of C4 and C5. Posterior end of the foreign body was at the mid of the C4 vertebral body and the anterior end was supero-lateral to the left arytenoids cartilage. An air pocket and collection of fluid from C4 to C6 vertebral level was noted causing antero-lateral displacement of pharyngeal and laryngeal wall. Other neck structures were normal and there was no lymphadenopathy. This feature is suggestive of a foreign body in the left Para pharyngeal space with a Para pharyngeal abscess extending from C4 to C6 level.

Immediately patient was given antibiotics, analgesics, IV fluid and planned for early exploration of the neck to drain the abscess and removal of foreign body (Chicken bone) under general anaesthesia. We did laryngoscopy in the operation theatre. The foreign body could not be visualized and scope could not be passed into the cricopharynx because of edema.

Approximately 4 cm horizontal incision was given at the level of lower border of thyroid cartilage. Subcutaneous tissue and platysma muscle were divided using cutting diathermy. While separating deep fascia about 5-10 ml of pus came out which were sent for culture and sensitivity test. After complete drainage of the pus, the chicken bone was detected by the help of C-arm image (Figure -1) and removed (Figure- 2). Wound was closed in layers by keeping the suction drain in position.

Post operative period was uneventful. Patient was completely asymptomatic after surgery and drain was removed after 48 hours. With a course of antibiotics patient was discharged.

Discussion

Ingested foreign bodies are the most common problems encountered in the casualty ward or the otolaryngology clinic. Most of the time, the foreign body is impacted in the tonsil or in the base of the tongue [3].Fish bones are the most commonly ingested foreign body in Asian countries [4].

Hypo pharyngeal foreign bodies are usually found intraluminally. However there have been a few interesting case reports of extra luminal migration of foreign bodies which can either penetrate intramurally in the wall of hypopharynx or in the soft tissues of neck [1,2, 5].

Transversely oriented foreign bodies are more prone to perforate the wall of the hypopharynx. This happens due to the contractions of hypopharynx during deglutition which forces the foreign body to penetrate the wall. In our case patient manipulated the site of foreign body which may be the cause of migration.

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Migrating extra luminal foreign bodies from pharynx need careful evaluation. Patient may be symptom free or develop persistent symptoms due to foreign body lodgment or its complications thereof. They may cause suppurative complications such as deep neck abscesses, mediastinitis [6] or vascular complications due to penetration of carotid artery, its branches and the internal jugular vein [7]. Evaluation of these cases with radiograph neck can show the presence of a foreign body if it is radio opaque. Diagnosis and the exact location of foreign body can be established with CT scan of the neck. In asymptomatic patient, foreign body removal can be deferred and the patient kept under regular follow-up [8]. Surgical intervention by lateral neck exploration is indicated in symptomatic patients [9].

Conclusion

Pharyngeal extra luminal migrating foreign bodies are uncommon occurrences. Usually Patient presents with the history of foreign body ingestion with meals. A careful radiological and endoscopic evaluation detects extra luminal migration of foreign bodies. Symptomatic patients and those with complications should undergo surgical removal. In the present case foreign body from the hypo pharynx has migrated to the Para pharyngeal space which was removed by external neck approach.

(Figure – 1 – C arm image of foreign body)

(Figure -2 – Foreign body in Para pharyngeal space)

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