



THE UNSCHEDULED GUESTS REVISITED: OUTCOMES OF ENDOSCOPIC AND SURGICAL MANAGEMENT OF GASTROINTESTINAL FOREIGN BODIES

General Surgery

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ABSTRACT

Background: Foreign body ingestion or insertion into the gastrointestinal tract (GIT) is a frequently encountered emergency in surgical and gastroenterological practice. The incidence is highest among the paediatric population, particularly children aged 6 months to 6 years, while other high-risk groups include patients with psychiatric disorders, prisoners, alcohol-intoxicated individuals, and elderly patients with dentures [1–3]. The spectrum of foreign bodies is broad, ranging from coins and button batteries to sharp metallic objects and rectally inserted items of varying size and shape [4]. Approximately 80–90% of ingested foreign bodies pass spontaneously through the gastrointestinal tract without intervention. Endoscopic removal is required in nearly 10–20% of cases, whereas surgical intervention is necessary in fewer than 1% of patients, usually in the presence of complications such as obstruction, perforation, bleeding, or sepsis [5–7]. Management is guided by several factors, including the type and size of the foreign body, anatomical location, duration since ingestion, patient age, and evidence of complications [5]. The present case series illustrates the clinical heterogeneity associated with gastrointestinal foreign bodies. Most patients were children presenting with coin or sharp object ingestion, consistent with the predominance reported in pediatric literature [7]. One adult with psychiatric illness presented with delayed small bowel impaction, while another adult required operative management for rectal foreign body insertion complicated by sepsis [8,9]. Urgent endoscopic removal was performed in pediatric patients with proximal esophageal impaction, and surgical intervention was required in a case of button battery ingestion due to impending perforation following unsuccessful endoscopic retrieval. Conversely, selected clinically stable patients were managed conservatively with successful spontaneous expulsion. Overall, this institutional experience parallels findings reported in existing literature and emphasizes the importance of early diagnosis, risk stratification, and individualized management strategies to optimize clinical outcomes [1,5].

KEYWORDS

INTRODUCTION

Foreign body ingestion and insertion within the gastrointestinal tract (GIT) represent common emergencies encountered in emergency medicine, surgical, and gastroenterology practice [1–3]. The condition predominantly affects children younger than six years due to exploratory behaviour and accidental ingestion. In adults, foreign body ingestion is more often associated with food bolus impaction, psychiatric illness, substance abuse, alcohol intoxication, and deliberate insertion, including rectal foreign bodies [6,8,9]. Retained surgical materials and diagnostic devices may also occasionally function as gastrointestinal foreign bodies [1].

Several anatomical narrowing points within the gastrointestinal tract predispose to foreign body impaction, including the cricopharyngeal region, mid-esophagus, lower esophageal sphincter, pylorus, ileocecal junction, and anal canal [1,3]. In addition, pathological conditions such as strictures, tumors, diverticula, and motility disorders increase the likelihood of obstruction and delayed passage [3].

Clinical presentation varies depending on the type and location of the foreign body. Patients may present with dysphagia, odynophagia, chest discomfort, nausea, vomiting, abdominal pain, or signs of intestinal obstruction and perforation [5,6]. Diagnosis is primarily based on clinical history and physical examination; however, imaging plays a critical role when history is unreliable, particularly in pediatric patients and individuals with psychiatric illness. Plain radiography is the preferred initial investigation for radiopaque objects, whereas computed tomography and endoscopy are useful for radiolucent foreign bodies and complicated presentations [5–7].

Most ingested foreign bodies pass spontaneously without intervention. Nevertheless, a subset requires endoscopic retrieval, and a small proportion necessitates surgical management due to complications

such as perforation, obstruction, bleeding, or sepsis [6–10]. Early identification of high-risk foreign bodies, particularly button batteries and sharp objects, is essential to reduce morbidity and prevent life-threatening complications [7].

This case series describes seven patients with ingested or inserted gastrointestinal foreign bodies across different age groups and highlights the variability in clinical presentation, diagnostic evaluation, and individualized management strategies that resulted in favorable outcomes without significant complications.

AIMS AND OBJECTIVES

Aim

To evaluate the clinical profile, management strategies, and outcomes of patients presenting with gastrointestinal foreign bodies and to assess the safety and effectiveness of endoscopic and surgical interventions in a tertiary care centre.

OBJECTIVES

1. To categorize the types, anatomical location, and nature (blunt, sharp, battery, rectal insertion) of foreign bodies encountered.
2. To evaluate the role and success rate of endoscopic management in esophageal and gastric foreign bodies.

MATERIALS AND METHODS

- **Type of study:** Prospective Observational Case Series.
- **Sample size and source:** case series of 8 patients who underwent surgical procedure at the Department of General Surgery, Dr. B. R. Ambedkar Medical College and Hospital, Bangalore.
- **Study Period:** JANUARY 2024 to AUGUST 2025.
- **Management Protocol:** Every patient presenting with foreign body, a tailored decision specific to the concerning FB - for instance - emergent endoscopy for oesophageal FB/button

batteries, observation for blunt gastric FB, urgent surgery for signs of perforation.

Case Series

Case 1:

A 2-year-old male child presented to the emergency department with accidental foreign body ingestion 3 hours prior, followed by coughing and haemoptysis. There was no episodes of vomiting, cyanosis, choking. The child had no significant past medical history and developmental milestones were appropriate for age.

On general examination, the child was conscious and irritable, with mild tachycardia. There was no respiratory distress. Systemic examination was unremarkable, with normal respiratory, cardiovascular, and abdominal findings. Oropharyngeal inspection did not reveal a visible foreign body. Plain chest x-ray PA view demonstrated a radio-opaque circular shadow at the level of the proximal esophagus, consistent with coin impaction at the cricopharyngeal region. Laboratory parameters were within normal limits.

The symptomatic esophageal foreign body warranted urgent removal to prevent mucosal injury or airway compromise. The patient was kept nil per oral and underwent emergency rigid esophagoscopy under sedation. An impacted coin with mild mucosal congestion was visualized and successfully retrieved without complications.

Postoperatively, the child remained stable, tolerated oral feeds after 6 hours, and was discharged the following day.

This case emphasizes timely endoscopic intervention for symptomatic pediatric esophageal foreign bodies to achieve favorable outcomes with minimal morbidity.



a) fig : erect x-ray abdomen showing the FB(coin)
b) fig: endoscopic intervention

Case 2:

A 5-year-old female child presented to the emergency department with a history of accidental foreign body ingestion approximately 2 hours prior, followed by breathlessness. There was no history of cyanosis, vomiting, fever, or previous similar episodes. The child had no significant past medical history.

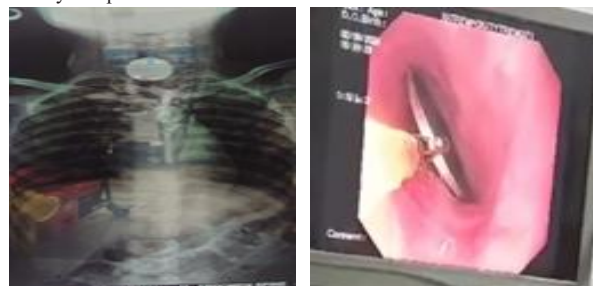
On general examination, the child was anxious with mild respiratory distress but maintained stable oxygen saturation. Vital parameters were within age-appropriate limits. There was no stridor or severe airway compromise.

Respiratory examination revealed normal bilateral air entry, and cardiovascular and abdominal examinations were unremarkable. Oropharyngeal examination did not reveal a visible foreign body. Plain chest X-ray PA view demonstrated a well-defined radio-opaque circular shadow at the level of the vocal cords, consistent with coin impaction in the proximal esophagus.

Given the presence of respiratory symptoms, urgent endoscopic removal was indicated to prevent airway obstruction and mucosal injury. The patient was kept nil per oral and underwent emergency rigid esophagoscopy under sedation. The coin was visualized and successfully retrieved under vision without complications. Postoperatively, the child showed immediate improvement in breathing within a few hours, tolerated oral feeds, and was discharged the following day.

This case highlights the importance of prompt endoscopic interven-

tion in symptomatic esophageal foreign body ingestion to prevent airway compromise and ensure favorable outcomes.



c) fig: X-ray chest & abdomen showing coin at upper respiratory tract
d) fig: shows endoscopic intervention

Case 3

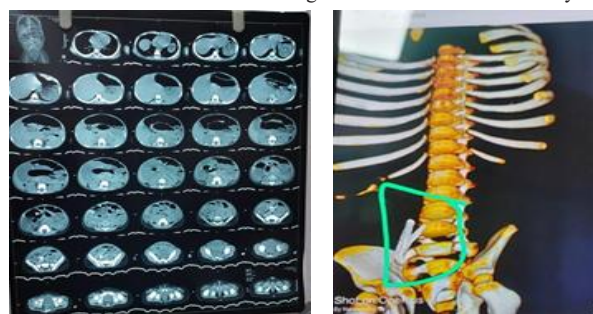
A 56-year-old male with known case of psychiatric illness presented with a 10-day history of progressively worsening abdominal pain and reduced oral intake. A reliable history of foreign body ingestion could not be elicited due to poor recall.

On evaluation, the patient was anxious and had tachycardia and hypotension; however, abdominal examination revealed localized guarding and rigidity in right iliac fossa, suggestive of localized peritonitis.

Laboratory parameters demonstrated leukocytosis. Erect x-ray abdomen showed dilated small bowel loops, Contrast-enhanced computed tomography (CECT) of the abdomen and pelvis revealed a linear metallic foreign body, impacted within the small bowel, associated with bowel wall thickening, peri-intestinal fat stranding, and features suggestive of impending perforation.

In view of delayed presentation and radiological evidence of localized inflammatory changes, the patient was taken up for emergency exploratory laparotomy. Intraoperatively, the foreign body was identified within the small intestine with surrounding inflammatory reaction but without frank perforation. An enterotomy was performed, and the foreign body was retrieved, followed by primary closure of the bowel. The postoperative course was uneventful, with restoration of bowel function and symptomatic improvement.

This case highlights the need for early cross-sectional imaging and a high index of suspicion in psychiatric patients, as delayed diagnosis is associated with increased risk of surgical intervention and morbidity.



e) fig: CECT abdomen showing FB
f) fig: 3D image reconstruction showing the exact location of FB

Case 4:

A 4-year-old male child presented to the emergency department 8 hours after accidental foreign body ingestion – battery cell, with severe abdominal pain. There was no history of vomiting.

On examination, the child was irritable with mild tachycardia. Abdominal examination revealed localized guarding and rigidity, suggestive of peritonitis.

An erect X-ray abdomen demonstrated a radio-opaque cylindrical foreign body consistent with a battery cell located in the distal stomach.

Given the high-risk nature of battery ingestion, the patient was kept nil per oral and taken for emergency endoscopic retrieval. During emergent endoscopy, the battery was identified in the distal part of stomach with mucosal erosion with inflammatory changes, raising suspicion of impending perforation. As endoscopic retrieval was unsuccessful due to impacted foreign body and local inflammatory changes with impending perforation, the decision was made to proceed with emergency exploratory laparotomy.

Intraoperatively, the foreign body was identified within the distal end of stomach with surrounding inflammatory changes but without frank perforation. The battery was removed via enterotomy, and the bowel was closed primarily. The postoperative course was uneventful, with gradual resumption of feeds and clinical improvement.

This case highlights the aggressive tissue injury associated with alkali released from battery ingestion and emphasizes the importance of early intervention and surgical readiness when endoscopic retrieval fails.



g) fig: intra-op image of enterotomy with FB being Battery

Case 5

A 17-year-old female presented to the emergency department with a history of accidental foreign body ingestion -ball pin approximately 6 hours prior. The patient was asymptomatic at presentation, with no complaints of abdominal pain, vomiting, dysphagia, or respiratory distress. There was no significant past medical history.

On clinical examination, the patient was hemodynamically stable. Abdominal examination was soft and non-tender, with no signs of peritonitis. Respiratory and cardiovascular examinations were unremarkable. An erect abdominal X-ray demonstrated a linear radio-opaque foreign body consistent with a ball pin located in small bowel loops, without evidence of obstruction or perforation.

Given the patient's stable clinical status and location of the foreign body, a conservative management approach was adopted. The patient was advised serial clinical monitoring and follow-up imaging to assess progression of the foreign body. Dietary precautions and warning signs for complications were explained.

Serial radiographs demonstrated gradual distal migration of the foreign body, and spontaneous expulsion was confirmed after 6 days without complications. The patient remained asymptomatic throughout the observation period.

This case illustrates that selected sharp foreign bodies can be managed conservatively under close surveillance, provided there are no clinical or radiological signs of complication.



h) & i) fig: serial X-rays of erect abdomen showing FB (ballpin)

Case 6

A 9-year-old child presented to the emergency department with a history of accidental coin ingestion approximately 6 hours prior to arrival. The child remained asymptomatic, with no complaints of

dysphagia, vomiting, abdominal pain, cough, or respiratory distress. There was no significant past medical history.

On examination, the child was hemodynamically stable. General and systemic examinations were unremarkable, and abdominal examination revealed a soft, non-tender abdomen without signs of obstruction or peritonitis. An erect X-ray abdomen demonstrated a well-defined radio-opaque circular shadow consistent with a coin located within the gastric region, with no evidence of perforation or obstruction.

Given the asymptomatic presentation and location of the foreign body, conservative management was initiated. The patient was advised observation with serial clinical assessment and radiographic follow-up to monitor progression of the coin through the gastrointestinal tract. Caregivers were counseled regarding warning symptoms including abdominal pain, vomiting, or failure to pass stools.

Follow-up imaging demonstrated gradual distal migration, and spontaneous expulsion was confirmed after 9 days without complications. The child remained clinically stable throughout.

This case highlights that asymptomatic blunt foreign bodies beyond the esophagus can be safely managed conservatively with close monitoring and parental counseling.



j) & k) Serial X ray imaging of erect abdomen showing FB

Case 7

A 38-year-old male presented to the emergency department with abdominal pain, fever, and features of sepsis following insertion of a foreign body through the rectum. The patient reported progressive abdominal discomfort and difficulty in passing stools.

On examination, the patient was febrile and tachycardic. Abdominal examination revealed diffuse tenderness with generalised guarding and rigidity, raising suspicion of bowel injury. Digital rectal examination was limited due to patient discomfort and did not allow retrieval of the object.

Erect X-ray abdomen demonstrated a large radio-opaque conical foreign body measuring approximately 10 cm located at the rectosigmoid junction. Given the presence of systemic toxicity and concern for impending perforation, conservative or transanal retrieval was deemed unsafe. The patient was taken up for emergency exploratory laparotomy. Intraoperatively, the foreign body was identified within the rectosigmoid region with surrounding inflammatory changes but no frank perforation. The object was carefully removed, and the bowel integrity was preserved. Thorough peritoneal lavage was performed. The postoperative course was uneventful with resolution of sepsis and gradual return of bowel function.

This case highlights that rectal foreign bodies presenting with systemic signs require prompt surgical intervention to prevent perforation and severe complications.



**l) Fig L) Xray of Pelvis Shows Fb In Anal Canal
M) Fb Retrieved**

Case 8

A 4-year-old male child presented to the emergency department with a history of accidental foreign body ingestion of a stapler pin approximately 2 hours prior. The child was mildly symptomatic with complaints of coughing but no vomiting or hematemesis, respiratory distress, or abdominal pain. There was no significant past medical history.

On general examination, the child was conscious, hemodynamically stable, and maintaining adequate oxygen saturation. Systemic examination was unremarkable. Oropharyngeal inspection did not reveal a visible foreign body. Given the ingestion of a sharp object, urgent imaging was performed.

Chest x-ray PA view was taken and was found to be normal. An erect X-ray abdomen demonstrated a linear radio-opaque foreign body consistent with a stapler pin lodged in the lower esophagus. In view of the high risk of mucosal injury and perforation associated with sharp foreign bodies, the patient was kept nil per oral and taken for emergency endoscopic retrieval. Rigid esophagoscopy under general anesthesia revealed the stapler pin impacted in the lower esophagus with minimal surrounding mucosal erythema. The foreign body was successfully retrieved using grasping forceps without complications. The postoperative course was uneventful, oral feeds were resumed after observation, and the child was discharged the following day.

This case emphasizes prompt endoscopic removal of sharp esophageal foreign bodies to prevent perforation and mediastinal complications.



n) Endoscopic visualization of FB i.e stapler
o) Endoscopic retrieval

DISCUSSION

Gastrointestinal foreign bodies represent a heterogeneous clinical problem that requires tailored management based on the nature of the object, its location, and the presence of complications. This case series examined outcomes using a hypothesis-based comparison between endoscopic and surgical management.

6.1 Hypothesis

Null Hypothesis (H_0):

There is no significant difference in clinical outcomes between patients with gastrointestinal foreign bodies managed endoscopically and those managed surgically.

Alternative Hypothesis (H_1):

Endoscopic management of gastrointestinal foreign bodies, when performed in appropriately selected patients, is associated with favorable clinical outcomes and lower morbidity compared to surgical intervention, while surgery remains essential in complicated or failed endoscopic cases.

The findings in our case series favor the alternative hypothesis, indicating that endoscopic intervention in appropriately selected patients is associated with effective resolution and reduced morbidity, whereas surgical management remains indispensable in complicated or failed cases.

Endoscopic retrieval in pediatric patients with esophageal foreign bodies such as coins and sharp objects resulted in prompt symptom resolution without complications, supporting current recommendations that prioritize early endoscopic removal to prevent mucosal injury, perforation, and airway compromise^{5,6}.

Surgical intervention was required in patients presenting with sepsis, distal impaction, or signs of impending perforation, where operative

treatment allowed definitive management and favorable recovery.

Evidence from surgical outcome studies similarly demonstrates that although most foreign bodies pass spontaneously or are removed endoscopically, a small subset requires operative intervention due to complications^{11,12}. Conservative observation was effective in clinically stable patients with radiological evidence of distal migration, reinforcing guideline-supported expectant management in selected cases^{5,7}. Collectively, these findings highlight the importance of a stepwise treatment strategy that prioritizes minimally invasive techniques while ensuring timely surgical escalation when necessary, with early recognition of high-risk objects such as button batteries and sharp materials playing a key role in reducing morbidity.

Classification of Cases According to Hypothesis

Group A – Endoscopic

Case Number	Age {in years}	Foreign Body	Location	Indication	Outcome	Morbidity
Case 1	2 yrs	Coin	Proximal esophagus	Hemoptysis	Successful removal	None
Case 2	5 yrs	Coin	Upper esophagus	Breathlessness	Successful removal	None
Case 8	4 yrs	Stapler pin	Lower esophagus	Sharp object	Successful removal	None

Management (Favorable Outcome Group)(Testing Alternative Hypothesis: Lower morbidity in appropriately selected cases)

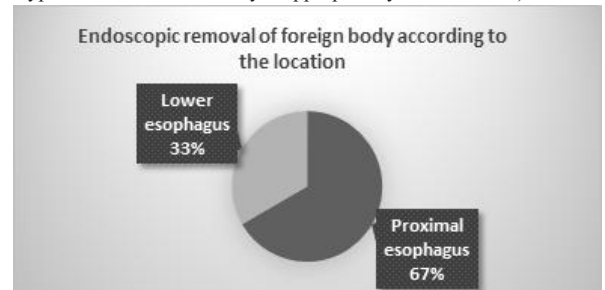


Figure p): Distribution of Management Modalities in Gastrointestinal Foreign Body Cases

Pie chart demonstrating the distribution of management modalities, showing equal utilization of endoscopic and surgical interventions, with conservative management in selected stable patients.

Inference for Group A

- All esophageal foreign bodies managed endoscopically, 100% success rate.
- No procedural complications, Minimal hospital stay.
- Supports Alternative Hypothesis (H_1) — Endoscopic management in selected cases is safe and effective with low morbidity.

Group B – Surgical Management (Complicated Cases Group)

(Represents patients requiring surgery due to complication or failed endoscopy)

Case number	Age	Foreign Body	Location	Indication for Surgery	Outcome	Morbidity
Case 3	56 yrs	Metallic clip	Small intestine	Peritonitis	Enterotomy done	Moderate
Case 4	4 yrs	Battery	Distal stomach/ileum	Failed endoscopy, mucosal erosion	Laparotomy	Mild
Case 7	38 yrs	Conical object	Rectosigmoid	Sepsis	Laparotomy	Moderate

Inference for Group B

- Surgery required in presence of:
 - Peritonitis
 - Sepsis
 - Impending perforation
 - Failed endoscopy
- Higher morbidity compared to endoscopic group.
- Longer hospital stay.

Does not reject H_0 completely, but supports that surgery is essential in complicated cases.

Group C – Conservative Management (Spontaneous Expulsion Group)

Case number	Age	Foreign Body	Location	Outcome
Case 5	17 yrs	Ball pin	Gastric	Passed spontaneously
Case 6	9 yrs	Coin	Gastric	Passed spontaneously

Inference for Group C

- Stable patients
- No complications
- Supports selective observation strategy

Statistical Nature of Study

Since sample size is small (n=8), statistical significance cannot be calculated reliably. Therefore:

- The case series clinically supports the Alternative Hypothesis (H_1).
- Surgery remains indispensable in complicated or failed endoscopic cases.
- Outcomes correlate more with disease severity at presentation rather than procedure type alone.

RESULTS:

Comparative Statistical Analysis

Table 1: Comparison of Outcomes Based on Management Modality

Parameter	Endoscopic (n=3)	Surgical (n=3)	Conservative (n=2)	Total (n=8)
Mean Age (years)	3.7	32.7	13	—
Pediatric Patients	3 (100%)	1 (33%)	1 (50%)	5 (62.5%)
Adult Patients	0	2 (67%)	1 (50%)	3 (37.5%)
Indication	Esophageal impaction	Peritonitis / Sepsis / Failed endoscopy	Stable, distal FB	—
Success Rate	100%	100%	100%	100%
Procedure-related Complications	0	0	0	0
Morbidity (Clinical Severity)	Minimal	Moderate	Nil	—
Mean Hospital Stay (approx.)	1–2 days	5–8 days	Outpatient / Short stay	—
Mortality	0	0	0	0

Table 2: Distribution of Foreign Bodies by Location and Intervention

Location	Number of Cases	Endoscopic	Surgical	Conservative
Proximal Esophagus	2	2	0	0
Lower Esophagus	1	1	0	0
Gastric	3	0	1	2
Small Intestine	1	0	1	0
Rectosigmoid	1	0	1	0

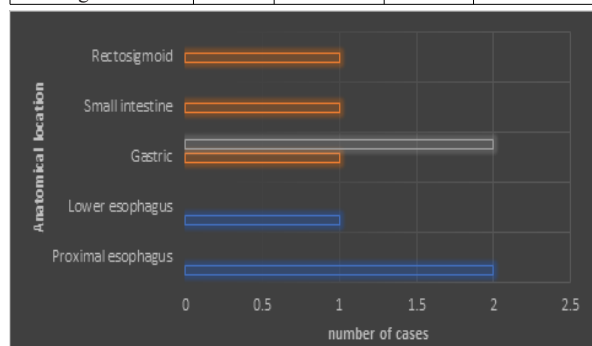


Figure 3. Anatomical Location of Foreign Bodies and Corresponding Management Modality

Location-based analysis demonstrated that esophageal foreign bodies were uniformly managed endoscopically, while distal gastrointestinal and rectosigmoid foreign bodies required surgical intervention or conservative observation.

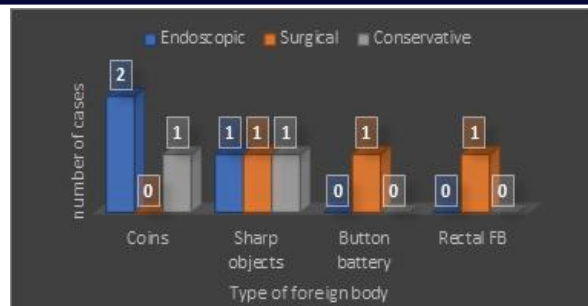


Figure 4. Management Modality According to Type of Foreign Body

Type-based analysis demonstrated that blunt objects were frequently managed endoscopically or conservatively, whereas button battery and rectal foreign bodies required definitive surgical intervention.

Table 3: Type of Foreign Body and Management

Type of FB	Number	Endoscopic	Surgical	Conservative
Coins	3	2	0	1
Sharp Objects (Pin/Clip/Stapler Pin)	3	1	1	1
Button Battery	1	0 (failed attempt)	1	0
Rectal Conical Object	1	0	1	0

Interpretation

- Endoscopic management accounted for 37.5% (3/8) of cases with zero morbidity.
- Surgical intervention accounted for 37.5% (3/8) and was associated with longer hospital stay and higher clinical severity, reflecting advanced presentation rather than procedural risk.
- Conservative management was successful in 25% (2/8) of carefully selected stable patients.
- Overall survival rate was 100%.
- No procedure-related mortality observed.

Given the small sample size, statistical significance testing (Chi-square or Fisher's exact test) is not meaningful. However, descriptively, outcomes support the hypothesis that:

Endoscopic management in appropriately selected cases is associated with lower morbidity compared to surgical intervention, while surgery remains essential in complicated presentations.

DISCUSSION

Gastrointestinal foreign body ingestion remains a frequent emergency across all age groups, with children representing the majority of affected patients. Consistent with previously published data, coins were the most commonly encountered objects in this series. Large observational studies indicate that most ingested foreign bodies pass spontaneously, whereas a smaller proportion require endoscopic retrieval and only a minority need operative management^{6,13}. The distribution of conservative, endoscopic, and surgical management in our series reflects this established pattern and was largely determined by clinical presentation and object characteristics.

Current recommendations from NASPGHAN and ASGE emphasize urgent endoscopic removal for symptomatic esophageal foreign bodies, particularly coins and sharp objects. In our study, all esophageal foreign bodies were successfully retrieved endoscopically with minimal morbidity, mirroring reported success rates above 95%^{6,7}. Button battery ingestion represents a high-risk scenario because of rapid mucosal injury and potential perforation. Similar to previously reported series demonstrating increased operative requirements after distal migration or failed retrieval, our battery ingestion case required surgical removal following unsuccessful endoscopic management^{7,11,12}. Delayed presentation also emerged as a key determinant of complications; literature demonstrates a marked rise in perforation risk beyond 24–48 hours, which was reflected in our patient with prolonged symptoms requiring laparotomy^{11,12}.

Rectal foreign bodies constitute a smaller but clinically important subgroup. Published reports indicate that complicated or septic presentations frequently require operative intervention, an observation consistent with our experience^{8,9,10}. Overall, our findings support

existing evidence that management outcomes are primarily influenced by object type, anatomical location, and timing of intervention rather than patient age alone.

Predictors of Surgical Intervention

In this series, the need for surgery was associated with identifiable clinical and object-related factors. Patients requiring operative management commonly presented with delayed symptoms, systemic inflammatory features such as sepsis, high-risk foreign bodies including button batteries and sharp metallic objects, distal gastrointestinal impaction, and failed endoscopic retrieval. Similar predictors have been consistently described in the literature, where delayed presentation, caustic or sharp objects, distal obstruction, and evidence of perforation increase the likelihood of surgical intervention^{11,12,13}.

Conversely, proximally located esophageal foreign bodies were successfully managed endoscopically, while stable blunt objects demonstrating radiological progression were suitable for conservative observation. These findings suggest that early presentation and object characteristics are the most important determinants of treatment pathway. Recognition of these predictors may aid risk stratification, support timely escalation of care, and reduce morbidity associated with delayed intervention. Timely clinical assessment combined with imaging-based monitoring therefore remains central to effective gastrointestinal foreign body management.

CONCLUSION

Gastrointestinal foreign bodies represent a common surgical emergency affecting both pediatric and adult populations, with presentations ranging from incidental ingestion to life-threatening complications such as perforation, obstruction, and sepsis. Successful management depends on early recognition, accurate localization, and timely intervention. Plain radiography remains the primary imaging modality for initial assessment, while contrast-enhanced computed tomography is particularly valuable in complicated or delayed presentations for guiding operative planning.

Endoscopic retrieval remains the cornerstone of treatment for esophageal and proximal gastrointestinal foreign bodies, demonstrating high success rates and low morbidity when performed promptly^{6,7}. Selected blunt foreign bodies beyond the second part of the duodenum may be managed conservatively with close clinical and radiological follow-up. Surgical intervention becomes necessary in high-risk situations, including failed endoscopic retrieval, ingestion of button batteries or sharp objects with complications, delayed presentation, and rectal foreign bodies associated with systemic toxicity^{11,12,13}.

Our institutional experience demonstrates that a structured, protocol-driven approach that prioritizes minimally invasive strategies while ensuring timely surgical escalation results in high removal success and acceptable morbidity. Management decisions should be guided primarily by foreign body characteristics, anatomical location, and timing of presentation rather than patient age alone.

Conflicts of Interest: There is no conflict of interest regarding the publication of this paper.

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