

Fishbone-Type Pharyngeal Foreign Body with Cutaneous Migration in the ENT Department of the Mamou Regional Hospital: A Case Report

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Abstract

We report a case of pharyngeal foreign body with cutaneous migration in the form of a fishbone in a 24-year-old rural resident, presented with odynophagia, dysphagia, pain and left antero-latero-cervical swelling fistulated to the skin following ingestion of a fishbone during a meal that had been evolving for 2 weeks. Vital parameters were normal, with an unremarkable psychological examination. Clinical examination revealed a left antero-latero-cervical swelling that was painful to palpation, fistulous to the skin and draining frank pus, revealing a sharp fishbone. A standard X-ray showed that the foreign body had exited the pharynx and was located in the soft tissues of the lower neck. An exploratory cervicotomy was performed, allowing extraction of a serrated fishbone. The post-operative course was favorable.

Keywords

Pharyngeal Foreign Body, Migrant, Otolaryngology, Mamou Regional Hospital

1. Introduction

Foreign bodies (FBs) are a frequent pathology in ENT [1]. Ingested foreign bodies are numerous and frequent, and their archiving is inadequate [2]. Their location or nature can be life-threatening [3]. Due to their fine, linear and sharp structure, fish bones tend to lodge and penetrate the esophageal mucosa in the

thyroid gland space as a result of the swallowing movement [4]. Publications on this subject are rare in our context. The aim of this study is to present our experience in the management of this unique case in our department, and to compare it with the data in the literature on this subject.

2. Clinical Case

A 24-year-old Merchant patient living in a rural area was admitted to our department on June 30, 2021 with odynophagia, dysphagia, pain and left antero-latero-cervical swelling fistulizing to the skin following ingestion of a fish bone during a meal. Vital parameters were normal, with an unremarkable psychological examination. The onset of symptoms was reported to be 2 weeks ago. Her history and lifestyle were unremarkable.

On June 15, 2021, during a meal, he allegedly ingested a fish bone which caused dysphagia and odynophagia, prompting a consultation in a local medical department, where he was given a prescription for an antibiotic and painkiller.

Two days later, given the persistence of the symptoms, he consulted a traditional practitioner, where he received a traditional treatment based on tree bark and plants, followed by massages.

A week later, he developed a painful left laterocervical swelling, fever and progressive worsening. Faced with these symptoms, he consulted our department for better management.

He was presented with an unsatisfactory general condition, a fistulized left laterocervical swelling with frank pus centered by a fishbone with jagged edges, and cervical stiffness (Figure 1). A face and profile cervical X-ray was taken, revealing a foreign body in the soft tissue of the lower neck on the left side (Figure 2). The diagnosis of a foreign body (fishbone) was accepted and an exploratory cervicotomy was decided.



Figure 1. Image showing the fistulated left laterocervical swelling and FB.

After an aptitude assessment, direct hypo-pharyngo-laryngoscopy was performed under general anaesthesia after orotracheal intubation, revealing a breach with frank pus emission at the lateral wall of the left piriform sinus. Esophagoscopy not performed due to lack of material.

Exploratory cervicotomy revealed 30 cubic centimeter (cc) of foul-smelling pus and a fishbone implanted in the left sternocleidomastoid muscle (**Figure 3**). Extraction of a fishbone measuring 4.5 centimetres in length (**Figure 4**).

He received antibiotic therapy with Ampicillin 1 g (1 g \times 2/d; for 7 days) and infusable paracetamol 1 g (1 g \times 3/d; for 3 days). This was followed by amoxicillin-clavulanic acid 1000 mg (1 g \times 2 d; for 8 days) and paracetamol 1 g (1 g times 2 per day for 5 days). The post-operative course was unremarkable, and the

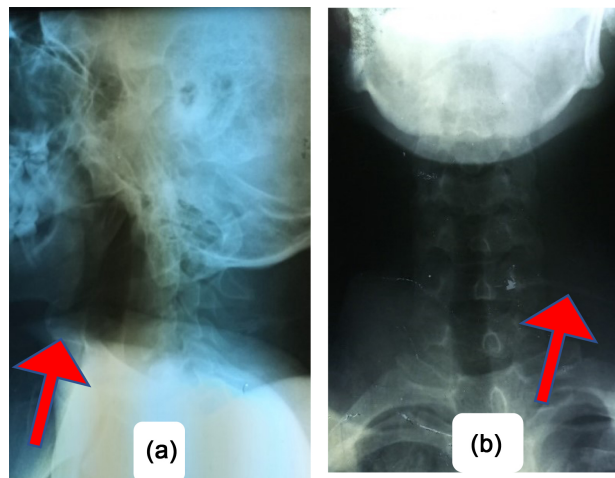


Figure 2. (a) profile X-ray of the neck with evidence of extra-luminal horizontal radiopaque FB opposite the 5th cervical vertebra; (b) frontal X-ray of the neck with evidence of extra-luminal horizontal radiopaque FB opposite the 4th cervical vertebra. The red arrows show a linear, thread-like, horizontal opacity suggestive of a foreign body.

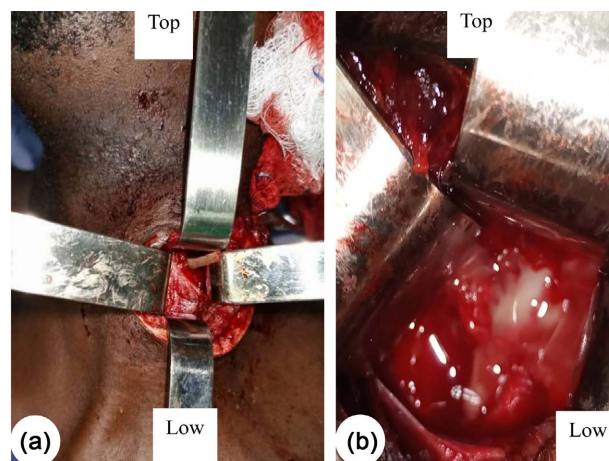


Figure 3. (a) intraoperative image showing fishbone; (b) intraoperative image showing frank pus.



Figure 4. Image of extracted foreign body (fishbone).

patient was discharged on the 7th day after surgery. After 6 months, healing was good.

The anonymity was strictly respected.

The patient's free and informed consent has been obtained beforehand.

3. Discussion

Food foreign bodies (meat, fish bone, bone) and dentures are mainly seen in adults. They can cause complications such as perforation and infection [5].

Sharp foreign bodies must be extracted as a matter of urgency, given the risk of esophageal perforation. Their secondary migration into the large vessels of the neck (internal jugular vein and primary carotid artery) represents a real danger, with life-threatening consequences [5].

The diagnosis is obvious in subjects who immediately consult an ENT specialist. However, a delay in consultation can occur when the patient lives far from a specialized center, as in the case we report. Diagnosis relies on clinical examination and cervico-thoracic radiography for radiopaque foreign bodies. Cervico-thoracic radiography can also be used to detect complications such as pneumothorax, pneumomediastinum and Minnigerode's sign (retro- and peri-oesophageal emphysema) [5].

The delay in the correct management of this patient, who presented with a foreign body initially incarcerated in the hypopharynx, was due to insufficient interdisciplinary collaboration and the important role played by traditional medicine in our context. The multiple manipulations favoured extra pharyngeal migration of the fishbone towards the cervical region.

Ingested foreign bodies migrate through the digestive tract without clinical manifestation or complication. Endoscopic extraction (esophagoscope) is reported by several authors to involve 10% - 20% of cases [6].

Major complications such as obstruction, perforation or abscessation occur in less than 1% of cases. This is the only case in our practice. Cutaneous migration is not uncommon.

Complementary examinations are crucial in these situations. Face and profile X-rays of the neck are frequently useful [4].

On the other hand, Chen Hai-hong *et al.* [7], Petrarolha SMP *et al.* [4] and Ohbuchi T *et al.* [8] have used computed tomography to pinpoint the precise location of thyroid-migrating foreign bodies. In our case, however, CT scans were not requested, due to the absence of CT scanners in our facility and our distance from the capital.

The use of cervicotomy for foreign body extraction is rare [1]. We performed a cervicotomy to remove the foreign body and drain the abscess.

After surgery, the postoperative course was straightforward, apart from discrete cervical scarring.

4. Conclusion

Extra luminal migration of ingested foreign bodies is rare. Delayed consultation and recourse to traditional medicine are thought to be at the root of complications. Recourse to surgery (cervicotomy) remains the ideal method for extracting these migrated CEs, in a context of under-medicalization.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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