Removal of An Extraluminal Oesophageal Foreign Body via the Lateral Pharyngotomy Approach: A Case Report

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Introduction
Fish bone impaction is one of the commonest ENT emergencies in Asia. The majority are partially intraluminal which allows visualisation and removal of the fish bone with rigid or flexible oesophagoscopy. On the contrary, extraluminal foreign bodies (FB) pose a challenge in diagnosis and retrieval.

Case
An 83 year old lady presented with odynophagia having eaten fish 16 hours prior. She complained of sharp pain in the left side of her neck. She denied chest pain and dyspnoea. No FBs were seen intra-orally nor on flexible nasoendoscopy.

Neck Exploration
A 4cm vertical incision was made over the left level IV neck. A subplatysma flap was raised and the strap muscles were retracted. The left thyroid lobe was mobilised medially and the recurrent laryngeal nerve was identified and preserved. An incision was made over the inferior constrictors and left lateral pharyngotomy was performed. A 2.5cm fish bone, identified by palpation at the upper oesophagus embedded in the anterior wall, was removed. The pharyngeal and upper oesophageal walls were closed in layers and a Penrose drained was placed.

Progress
The patient was maintained on NGT feeding post-operatively. On post-operative day (POD) 2, the patient developed stridor due to laryngeal oedema and required reintubation. She was noted to have unilateral left vocal cord palsy on POD 5. She was discharged on POD 11.

On her 6 months review, complete resolution of the left vocal cord palsy and swallowing dysfunction was noted and she resumed normal diet.

Discussion
• Fine-cuts CT\(^2\) is important for preoperative planning to localise an extraluminal FB, determine its configuration and to assess for any associated complications.

• The FB was a 2.5 cm fish bone that impacted in the left submucosal oesophagus.

• Penetrating FBs should be removed as soon as possible due to the high mortality of up to 45%\(^6\) arising from vascular complications and suppurative complications\(^1,4\).

• Transcervical, open neck exploration\(^4\) remains the technique of choice to remove these FBs. However, locating the FB intraoperatively remains the biggest challenge.

• Real-time intraoperative ultrasound is a new technique to localise submucosal foreign bodies in the pharynx and oesophagus and obviate the need for an open approach\(^7\).

• Postoperatively, patients who had a pharyngotomy or oesophagotomy are usually kept on NGT feeding to allow adequate wound healing\(^8\), until a contrast swallow has excluded a persistent perforation\(^9\).

• The complication rate of oesophagotomy for FB extraction has been reported to be 17.2% out of 29 cases, ranging from oesophageal suture line dehiscence, pharyngeal stricture, oesophageal fistula to serious wound infections\(^9\).

References

Figure 1: 1st, 2nd and 3rd contrast CT neck with blue arrow pointing to the foreign body and yellow arrow pointing to nasogastric tube.