AN UNUSUAL FOREIGN BODY IN THE TRACHEOBRONCHIAL TREE OF AN ICU PATIENT

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Introduction: Inhalation of foreign body by no means is an uncommon occurrence. The type of foreign bodies is almost endless and their enumeration is unnecessary. Gustav Killian in 1987 was the first person to remove a foreign body from the lower air passages with a rigid bronchoscope. During the first part of the twentieth century Chevalier Jackson perfected endoscopic techniques and made perioral endoscopy an important part of medical science. Foreign body can only enter the air passage if there is some interference with the normal reflex action, such as sudden inspiration while eating, playing, fright or laughter. In children probably the protective reflex is not as effective as in adults² therefore these accidents being more common in children as compared to adults. When the foreign body is first inhaled there is a bout of cough or dyspnea. The absence of a cough strongly rules out the possibility of foreign body having entered the air passage¹. One study³ has classified the thoracic foreign bodies in three types according to the etiology: Type-I being the ingested/aspirated, Type-II due to trauma/accident and Type-III iatrogenic. Foreign body ingestions or insertions are seen in four broad categories of patients: (a) children, (b) mentally handicapped or mentally retarded persons, (c) adults with unusual sexual behavior, and (d) ‘normal’ adults or children with predisposing factors or injurious situational problems.⁴

Objectives: to highlight the importance of fibre optic bronchoscope in foreign body removal in ICU setting

Methods: Here we are reporting a case of a young adult who accidentally aspirated a glass pieces of broken frontal glass of his accidentally crushed car, the aspirated glass pieces were lodged in his tracheobronchial tree and because the patient was deeply comatose and under ventilatory support, the glass pieces were discovered accidentally through our routine brain, cervical and chest CT scan as part of trauma imaging (Figure-1).

Results: An emergency fibro-optic bronchoscopy was planned and an informed and written consent was obtained for the procedure. Fibro-optic bronchoscopy was carried out under sedation { fentanyl and midazolam }. 1.1cm Fragment of glass was removed from the right main stem bronchus (Figure -2) as well as multiple fragments were scattered in his right lower lobe segments. Removal of these foreign bodies carried out utilizing the stone retrieval basket (dormia stone extractor, 2.5 fr, 0.8mm) through fibro-optic bronchoscope.

Conclusion: Of the tracheo-bronchial foreign bodies, only 12% will impact in the larynx with most passing through the cords into the tracheobronchial tree. Flexible fibro-optic bronchoscope is more easier and non traumatic for foreign body removal especially in already ventilated patients.
