CASE REPORT

Simple Question Towards Diagnosis: Did You Eat Fish?

Mohamad I, Abdul Manab FW

Mohamad I, Abdul Manab FW. Simple Question Towards Diagnosis: Did You Eat Fish?. *Malays Fam Physician.* 2017;12(3);40–41.

Keywords:
Foreign body, Pharynx, Neck, X-Ray Film

Authors:

Irfan Mohamad
(Corresponding author)
MD, M.Med (ORL-HNS)
Department of ORL-HNS
School of Medical Sciences,
Universiti Sains Malaysia Health
Campus, 16150 Kota Bharu,
Kelantan, Malaysia.
Email: irfankb@usm.my

Farah Wahida Abdul Manab
MD, M.Med (ORL-HNS)
Department of ORL-HNS
School of Medical Sciences,
Universiti Sains Malaysia Health
Campus, Malaysia.

Case Summary

A 35-year-old male complained of an acute onset of mild odynophagia with sharp pricking pain during swallowing. However, he was still able to tolerate oral intake of both solid food and fluid. There was no neck swelling, fever, voice change, or shortness of breath. Examination of the neck, oral cavity, and oropharynx was normal. Laryngoscopy also revealed normal findings.

Figure 1.

Figure 2.

Questions

1. What is the most important, but missed, question in the history?
2. What is the role of a neck radiograph?
3. When is a referral needed?

Answers:

1. The most important question in history taking is that of any episode of having had a meal of bony meat. It is very important in the case of acute onset odynophagia. In this case, the patient admitted to having had a meal of fish, with bone, the night before. The patient may have accidentally swallowed a fish bone.

   Apart from a history of ingestion, which some patients might forget, especially if it occurred some time prior to the presentation, other symptoms, such as neck pain, swelling, or a pricking sensation in the neck, may also be presenting complaints.[1] There can also be signs of the foreign body's migration; on rare occasions, this can cause self-extrusion.[2]

   Migration tends to occur in a delayed presentation or a delayed referred case. The foreign body can migrate to the distal part of the alimentary tract, obstructing the lumen or perforating the lumen, and, thus, affecting adjacent structures.[1]

2. In the outpatient setting, the most important investigation to conduct is a soft tissue neck radiograph. The lateral view is the most sensitive in terms of picking up the opaque foreign body (**Figure 1**). When compared to the anteroposterior

view (**Figure 2**), the lateral view is plainly more helpful. In this case, the lateral view of the soft tissue neck radiograph clearly showed the foreign body at the C5-C6 vertebra level. However, there are normal calcifications that may mimic or obscure the view of the opaque foreign body. [3]

Undoubtedly, there are fish bones which are radiolucent or show opacity in various degrees.[4] This might lead to a misleading conclusion on the part of those who are unaware of their presence. With the persistence of symptoms, even with negative clinical examination findings or radiograph opacity, examination under anaesthesia may still be warranted. If, the symptoms still persist post procedure, a computed tomography (CT) scan should be obtained to rule out any migrated or impacted radiolucent foreign bodies. CT has been shown to be more effective in complicated cases than plain radiography.[5] However, it is not routinely used in all cases. The role of ultrasonography is not established; the subsequent step after a radiograph is to either examination under anesthesia or conduct a CT scan.

3. An urgent referral is needed in all cases of suspected foreign body ingestion. An appointment must not be delayed. Sharp foreign bodies, especially fish bones, have been shown to migrate to adjacent structures[1]. Given the vital anatomical structures present in the neck, a day's delay can result in catastrophic consequences.

   In this case, we proceeded with direct laryngoscopy and esophagoscopy under an emergency list. The intraoperative finding

Figure 3.

was a T-shape fish bone measuring 1.5 cm x 2 cm (**Figure 3**) at the level of 17 cm from the upper incisor with minimal slough and abrasion of the oesophageal mucosa. No laceration wound was seen on the mucosa. The patient was allowed orally with normal diet post operation and discharged in good health the very next day. Upon discharge, the patient must be advised to come back for a re-assessment as an outpatient, usually in one week's time. A course of antibiotics is also usually prescribed. Any symptoms of fever or odynophagia may warrant readmission due to the possibility of a secondary infection.

It is recommended that in any suspected case of a foreign body, either from history, examination, or a plain neck radiograph, an urgent referral be made because complications arising from prolonged impaction, distal dislodgement, or migration will increase morbidity.

References

1. Johari HH, Khaw BL, Yusof Z, Mohamad I. Migrating fish bone piercing the common carotid artery, thyroid gland and causing deep neck abscess. World J Clin Cases. 2016;4(11):375-379.

2. Jamal S, Irfan M, Nazim N. Spontaneous extrusion of migrated fish bone in the neck after 48 hours of ingestion. Bangladesh Journal of Medical Science. 2011;10 (2):129-132.

3. Chawla A, Eng SP, Peh WC. Clinics in diagnostic imaging (100). Migrated pharyngeal fish bone. Singapore Med J. 2004;45(8):397-402; quiz 403.

4. Irfan M, Ahmad Helmy AK, Wan Shah Jihan WD. Radio-opacity of commonly consumed bony fish in Kelantan, Malaysia. Med J Malaysia. 2012;67(5):491-493.

5. Pinto A, Muzj C, Gagliardi N, Pinto F, Setola FR, Scaglione M, Romano L. Role of imaging in the assessment of impacted foreign bodies in the hypopharynx and cervical esophagus. Semin Ultrasound CT MR. 2012;33(5):463-470.