

**CRITTER AS A SUSGLOTTIC FOREIGN BODY: ABOUT A CASE**

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**ABSTRACT**

Laryngo-tracheo-bronchial foreign bodies are a breathing emergency that can affect the prognosis of life.<sup>[1]</sup> Laryngeal localization is common and most often results in laryngeal dyspnea. A 42-year-old patient, with no pathological history, was received at the hospital ENT emergency department of flap specialties, 2 months after ingestion of water from then not drinking. The story revealed paroxysmal dyspnea with progressive aggravation dysphonia without notion of dysphagia. The physical examination objectified an anemic syndrome. Nasofibroscopy highlighted the foreign body interposed on the right ventricular band hindering the mobility of the homolateral vocal cord. The laryngeal foreign body is strongly suspected in clinical examination before laryngeal dyspnea, dysphonia and a straight cough. Generally, the notion of penetration syndrome, found in interrogation, comforts the practitioner in his diagnosis. This case we report reminds us of the importance of exploring all aerodigestive pathways in children in case of suspicion of ingestion or inhalation of a foreign body regardless of the clinical presentation.

**KEYWORDS:** critter; supraglottic; foreign body.

**INTRODUCTION**

Laryngo-tracheo-bronchial foreign bodies are a breathing emergency that can affect the prognosis of life.<sup>[1]</sup> Laryngeal localization is common and most often results in laryngeal dyspnea. It is a diagnostic and therapeutic emergency. The foreign body can be a completely innocuous incident or on the contrary be responsible for serious, sometimes vital, complications.<sup>[2]</sup> The evolution after extraction is usually favorable. The authors report a case of laryngeal foreign body with no signs of laryngeal appeal to discuss diagnostic and therapeutic aspects.

**OBSERVATION**

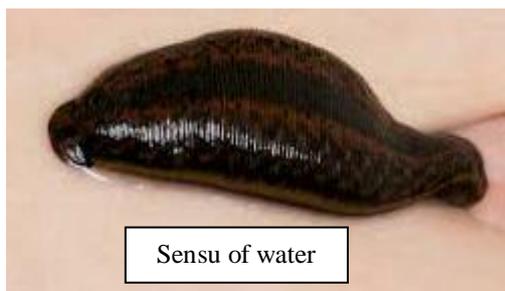
A 42-year-old patient, with no pathological history, was received at the hospital ENT emergency department of flap specialties, 2 months after ingestion of water from then not drinking. The story revealed paroxysmal dyspnea with progressive aggravation dysphonia without notion of dysphagia. The physical examination objectified a good general condition, a normal consciousness, eupneic with an anemic syndrome made of paleness and conjunctiva declaration. Nasofibroscopy highlighted the foreign body interposed

on the right ventricular band hindering the mobility of the homolateral vocal cord.

We removed the foreign body using a micro-clamp. It was a type animal cenus still alive hematophage feeds on the laryngeal mucosa and develops gradually in size. Blood work objectified anemia at 9g/dl.

Faced with these clinical and para-clinical signs, we concluded to a laryngeal foreign body and put the indication of emergency extraction. This was done by direct suspended laryngoscopy under sedation. Laryngeal exposure confirmed the nasofibroscopic findings.

After surgery, the patient was given antibiotic therapy (amoxicillin protected 1g 3 times a day for 5 days), analgesic (Paracetamol 500mg 4 times a day for 3 days) and corticosteroid (prednisolone 1mg/kg/day for 3 days) As well as iron supplements.



## DISCUSSION

The laryngeal foreign body is strongly suspected in clinical examination before laryngeal dyspnea, dysphonia and a straight cough. Generally, the notion of penetration syndrome, found in interrogation, comforts the practitioner in his diagnosis. In our case, only the notion of wearing by mouth of foreign objects of unspecified nature during the game was reported by the entourage. The absence of penetration syndrome in our patient could be explained by the position of the foreign body not restricting respiratory function. Also, the complete closure of the glottis in the process of phonation would not be thwarted by the foreign body.<sup>[3,4]</sup> The absence of laryngeal call signs should not obscure the careful physical examination of the patient based on nasofibroscope and especially not prevent or delay imaging.<sup>[4]</sup> In our case, nasofibroscope not only confirmed the diagnosis but gave an idea of the shape of the foreign body. The consultation time for laryngeal foreign matter varies depending on the circumstances. Vroh et al noted a relatively short consultation period. For them, dyspnea would be the main reason that parents, concerned, would have to consult early. Sometimes the patient is late due to a diagnostic delay in peripheral health centres.<sup>[3]</sup> Often the foreign body is unknown to the entourage, the child cannot explain himself clearly<sup>[4-5]</sup>, which also lengthens the time of consultation. Some patients are seen at the stage of complications with dyspnea, fatty cough, fever.<sup>[4]</sup> Migration into the trachea is possible with dyspnea at both times of breathing. Migration into a bronchus strain is also possible. Generally, the foreign body is found in the right bronchus because of its particular anatomy.<sup>[6-8]</sup> The treatment consists of extracting it urgently. The literature shows that endoscopic extraction to the rigid tube under general anesthesia is the most recommended method.<sup>[3,6,9]</sup> This extraction is carried out under sight control<sup>[3]</sup> by obeying the apophthegm of Chevalier Jackson which says that “any foreign body of the aerodigestive pathways that has entered through the natural pathways may be removed by the same pathways provided that it has not migrated through the perforated wall of these pathways”.<sup>[2,10]</sup> A tracheotomy can be associated depending on the circumstances. Indeed, it can be performed in emergency before a laryngeal dyspnea. According to Diop et al, despite the specific complications of tracheotomy, this is a practice that occupies a place of choice in the treatment whose interest lies in reducing the morbidity and mortality related to the

accident, especially in developing countries where the technical plateau is failing.<sup>[10]</sup>

## CONCLUSION

The presence of a foreign body in the larynx without any sign of laryngeal appeal is a rare fact. This case we report reminds us of the importance of exploring all aerodigestive pathways in children in case of suspicion of ingestion or inhalation of a foreign body regardless of the clinical presentation.

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