Magill's forceps in removing impacted foreign body

I Omar

Citation

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Abstract

Sir,

It is with interest I read the short letter indicating the use of Magill's Forceps for non anesthesia purposes. Most anesthesiologists used this forceps as it is available all the time for their immediate use. Sometime it was used for non anesthesia purposes [1]. It was interesting to me to see the described approach for dislodging and removing an impacted bolus of meat, in the lower third of esophagus, through the stomach.[2]

I had with a surgeon associate almost a similar situation but we were able to tackle the situation from the upper side of the esophagus. The incident happen when I was the anesthetist on call in one of the hospital, in Amman/Jordan in 2001, when a 70 yrs-old gentle man was booked for emergency rigid osophagoscopy to remove an impacted big bolus of meat in the mid esophagus.

After a rapid sequence induction and endotracheal intubation with appropriate maintenance of anesthesia and rigid osophagoscopy was carried out, but unfortunately failed to remove the piece of meat, as it is picked by the small objective arms of the forceps he is using. Many trials were done and every time failed to remove it as one piece and only small fragments were obtained.

Thinking together, we decided to try the adult size Magill's forceps, astonishingly, that was the most suitable instrument and the big piece of meat was taken completely out with the rigid osophagoscopy.

Another earlier incident happen when I was the anesthetist on call in one of the hospital, in Riyadh/ K.S.A. in 1990, when a 40 years old gentleman Pilipino nationality was booked for direct laryngoscopy, to remove an impacted fish bone that is seen in a plain x-ray of the neck just above the inlet of the larynx. The patient was still in ER when I met him for pre-op evaluation, after reassuring the patient and with his full cooperation; the ER Doctors examine him with the aid of head light and tongue depressor using the adult size Magill's forceps, the piece of bone was extracted in ER and OR procedure was cancelled.

This would indicate that even non anesthesiologists may try to use it under controlled condition outside operating theatre.

We may conclude; the moral from these stories is an emphasis on the possible role of observing anesthesiologist to solve problem in dire situation.

It indicate the role of Magill's forceps is an adjunct to airway management. So the emergency physician and surgeon who faces a situation of FB obstructing the airway in the depth of the oropharynx may ask for either the pediatric or adult size which may prevent the delay in sorting this problem out. I agree with the notion that the rigid osophagoscope or bronchoscope long forceps usually have short objective arms and when manipulation would be tried through the rigid, it may not be easy to control the FB.

References

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Author Information

Ihab Omar, MB ChB MS Anesth, CJBA
Consultant Anesthetist, Department of Anesthesia, King Fahad Medical City