

Penetrating Foreign Body in the Throat of a Magician

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Abstract

Sharp and pointed foreign bodies in the aero-digestive tract can result in potentially fatal complications. They can be safely removed by rigid endoscopy thereby avoiding open surgical methods, which may be required when there is perforation or abscess formation. Method: A 32 year old male magician presented with a day history of sewing needle in the throat, which accidentally got stuck while he was displaying in a magical feat. Result: Examination revealed pooling of saliva in the throat and lateral X-ray of the soft-tissue neck showed a linear radio-opaque wire-like object across the larynx and hypopharynx. The foreign body was retrieved with rigid laryngoscope under general anaesthesia.

Conclusion: Successful removal of the foreign body will prevent the occurrence of life threatening complications. Magicians who engage in display with dangerous and potentially fatal objects need to be discouraged from this act. We report a rare case of impacted sewing needle in the larynx of a 32 year old male magician, and share our experience in the management of this interesting case.

CASE REPORT

A 32-year-old magician, presented at ENT department of Federal Medical Centre, Gusau, Nigeria with a day history of a sharp pain in the throat following a meal. The pain was persistent and associated with dysphagia and odynophagia. On physical examination, there was pooling of saliva in the oropharynx and tenderness over the thyroid prominence. There were no signs or symptoms of respiratory distress or hoarseness. A lateral view of X-ray of the soft tissues of the neck revealed a densely radio-opaque linear shadow at the level of 4th-5th cervical vertebrae with its ends embedded in the retropharyngeal soft tissue and thyroid cartilage respectively (Fig1). The appearance was suggestive of a wire-like metallic object.

On further questioning, the patient admitted to being involved in magical display using needles, and has been doing so for several years. He claimed to have actually inserted a bunch of needles into his mouth and brought them out through the nose.

He was started on intravenous antibiotics and booked for rigid endoscopy and removal of the foreign body under general anaesthesia.

At surgery, there was pooling of secretions in the oropharynx, and the laryngeal inlet and posterior pharyngeal wall appeared oedematous and hyperaemic. We found a

rusty sewing needle measuring 4.5cm in length, lying across the laryngeal inlet with the butt and tip embedded in the pre-vertebral soft tissue and the anterior commissure, respectively. Using Mackintosh laryngoscope and foreign body grasping forceps, the needle was gently disimpacted. There was no evidence of pus collection in the pharynx or larynx. Post-operatively, he was placed on intramuscular dexamethasone for 48hrs and oral antibiotics for 1 week. He was counseled and discharged home after 24hrs. The post-operative period was unremarkable.

Figure 1

Figure 1: X-ray soft-tissue neck shows the foreign body in the throat (black arrow)



DISCUSSION

Most of the patients presenting to the emergency department with foreign body in the aero-digestive tract are in the pediatric age group.¹ Adults who are most prone to the impaction of a foreign body are those with esophageal strictures, psychologically unbalanced individuals,² and denture carriers. Our case does not fit into any of these categories. Onakoya et al.³ have reported a case of impacted rhino-pharyngeal sewing needles in a magician. In a series by Ahmad et al,⁴ two magicians presented with sewing needle in the hypopharynx and oesophagus each, while a 3rd patient was a child who had sewing needle stuck in his hypopharynx while trying to practice what the magicians did at a display. Magicians from the northern part of Nigeria are known for indiscriminate display with dangerous objects such as needles, nails or even knives. The government should legislate against this dangerous act.

Sharp foreign bodies (FB) in the aero-digestive tract could be complicated by abscess formation or the FB migrating into the soft tissue of the neck or other parts of the body such as gastrointestinal tract.^{5,6,7} This poses a serious challenge to the surgeon, especially if there is limitation of facilities in the area the patient is presenting. In some instances, the external approach may be the only option.⁵

Although, flexible endoscope could be used in removing FB in the aero-digestive tract, the use of rigid endoscope under

general anaesthesia is advocated for removal of sharp objects.⁸

While grasping the needle with a crocodile- action foreign body grasping forceps, the anterior part of the needle was gently disimpacted with the tip of Mackintosh laryngoscope blade, without any tear to the mucosa. The potentially fatal complication of this sharp foreign body was therefore avoided.

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