

Incidental Double Foreign Bodies Obstruction in the Oesophagus: Unusual Presentations in a 3-Year-Old at Amana Regional Referral Hospital

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ABSTRACT

Foreign body impaction in the oesophagus remains one of the most common paediatric medical emergencies and continues to be associated with significant morbidity and, in severe cases, mortality. Prompt recognition and emergency removal are therefore essential in order to prevent potentially life-threatening complications such as oesophageal perforation, mediastinitis, aspiration pneumonia, and strictures. Although the ingestion of a foreign body is often witnessed or reported, the diagnosis may occasionally be delayed or missed, particularly when the presentation is atypical or when initial symptoms are mild or absent. Such delays may lead to late diagnosis, misdiagnosis, and an increased risk of complications.

We present a case of a 3-year-old female child who was brought to the hospital with a three-day history of postprandial vomiting accompanied by a persistent dry cough. Notably, two weeks prior to presentation, there was a history of foreign body ingestion. At that time, the child remained asymptomatic and was reassured at a lower-level health facility that the object would pass spontaneously through the gastrointestinal tract. No imaging was performed, and the patient was discharged without further follow-up. Upon presentation to our facility, a chest radiograph was obtained and revealed a single spherical foreign body lodged in the oesophagus. Based on these findings, the patient was prepared for urgent removal by oesophagoscopy. Intraoperatively, however, an additional foreign body was unexpectedly identified and successfully extracted from a location proximal to the object visualized on the chest X-ray. This finding highlighted the possibility of multiple foreign bodies despite imaging suggesting a solitary object.

This case underscores the importance of maintaining a high index of suspicion in children with suggestive symptoms, obtaining appropriate imaging, and considering the possibility of multiple foreign body ingestion. Early referral and timely intervention remain crucial to reducing morbidity and improving outcomes in paediatric oesophageal foreign body cases.

Keywords: Double foreign body, Oesophagus, rigid oesophagoscopy

INTRODUCTION

Foreign body (FB) oesophagus remains one of the common medical emergencies that may lead to significant morbidity and mortality. It is common among paediatric age group, elderly, prisoners, and patients with psychiatric illness and mental retardation (1). In children many unsuspected foreign bodies are initially diagnosed as viral, upper respiratory, or gastrointestinal illnesses and may be discovered incidentally on a chest radiograph intended to rule out a pulmonary process (2).

Oesophageal foreign body is a relatively common complaint in the emergency room. The clinical presentation can be dysphagia, retrosternal pain, and occasionally abdominal pain (3), and it is often accompanied by serious medical conditions, such as cervical abscess, mediastinitis, aortooesophageal abscess, tracheoesophageal fistula, pneumonia, and pneumothorax, most of which are caused by oesophageal perforation. Thus, an oesophageal foreign body can lead to death if the diagnosis is significantly delayed (4).

Most of the cases of oesophageal foreign body would pass spontaneously but those that require intervention should be treated as soon as possible.

Case Presentation

A 3-year-old female child presented to our clinic with history of vomiting after eating for a duration of 3 days. This was more prominent when eating solid foods but could easily swallow liquids and was associated with dry cough with no difficulty in breathing, change of voice or abnormal sounds during breathing. There was no fever or body weakness.

A week before the onset of vomiting the child had history of ingesting foreign body, she was taken to a nearby health center whereby after physical examination the parents were reassured the child was fine and that the foreign body will be passed through faeces, and the child was discharged home.

A day before admission the child had more episodes of vomiting, this time involving liquid food such as porridge. She was taken to a nearby health center where she was then referred to Otorhinolaryngologist for further management.

At the otorhinolaryngology clinic, clinical history and physical examination was done. Her vital signs upon review at the clinic were as follows: temperature 36.9°C; heart rate 112 beats/min; respiratory rate 30 breaths/min and peripheral oxygen saturation of 98% in room air. The chest examination revealed bilaterally normal breath sounds, with no transmitted or wheezing sounds.

Chest x-ray was done which revealed radio-opaque opacification at the upper oesophagus (see figure 1A, B & C). The diagnosis at this stage was foreign body oesophagus. The child was admitted and direct oesophagoscopy was performed under general anaesthesia by using rigid paediatric oesophagoscope. Secretions were suctioned from the oesophagus and at the level of upper oesophagus 13cm from upper incisor, food contents were observed, suctioned and a baobab seed revealed (see figure 2A & B) obstructing the oesophagus and it was removed (first foreign body).

Again rigid paediatric oesophagoscopy was re-introduced and a roundish metallic foreign body covered with food contents was revealed (figure 2A & B) at the level of upper oesophagus (18cm from upper incisor). After removal of the metallic foreign body a nasogastric tube (NGT) was inserted, the child was observed and upon being fully awake she was transferred to paediatric ward where close monitoring for any features of mediastinitis or other complications was done. Antimicrobial and analgesic therapies were prescribed. The child was discharged from the paediatric ward on the 2nd day in a good condition with normal feeding.

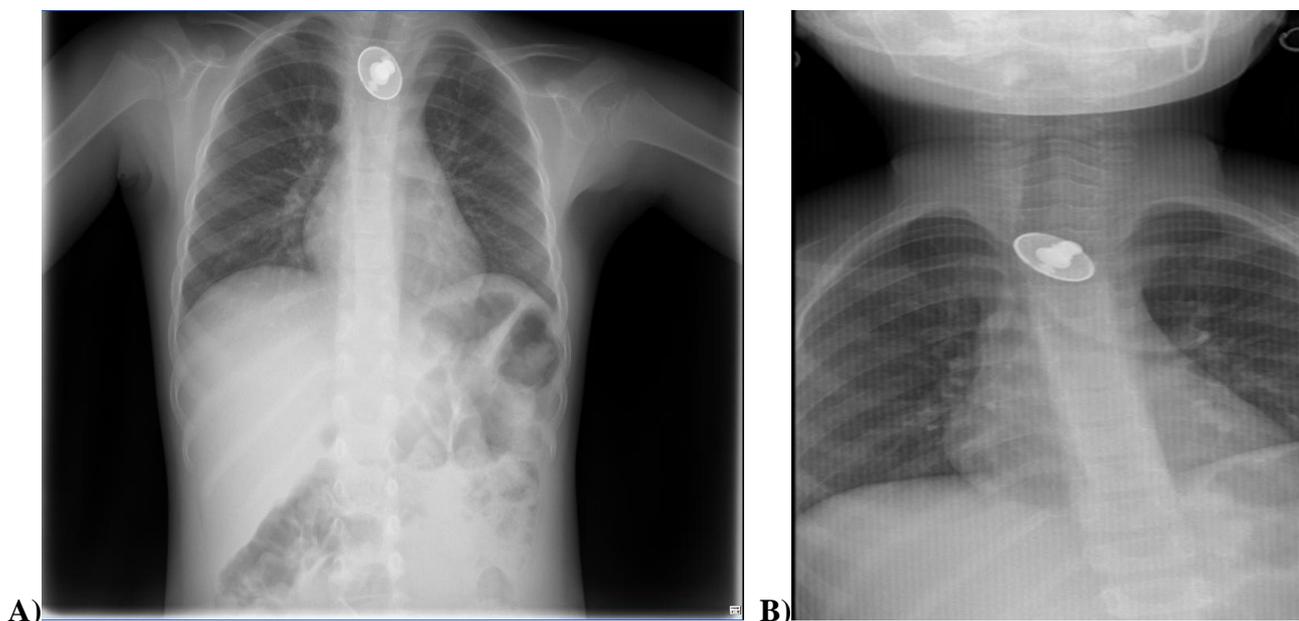


Figure 1 A & B. Anterior view of the Chest x-ray showing FB in the oesophagus

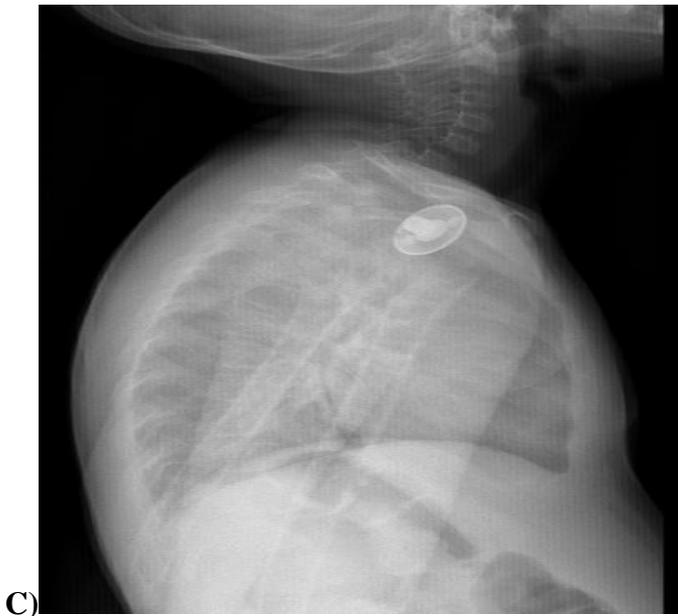


Figure 1 C. Lateral view of the Chest x-ray showing FB in the oesophagus

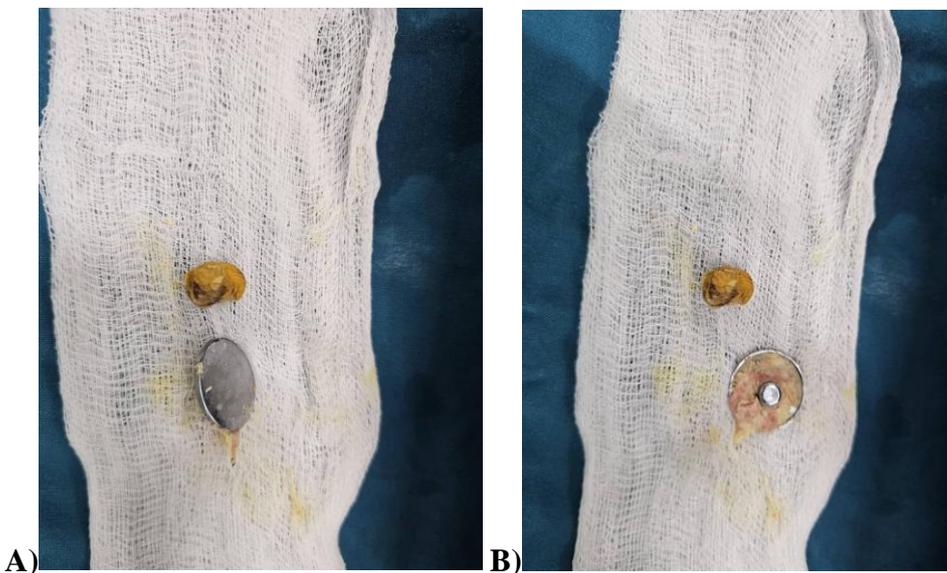


Figure 2 A & B: Showing foreign bodies after removal from the oesophagus

DISCUSSION

Studies have shown that food boluses, bone pieces and dentures (4%–18%) were found more common in elderly while coins and toys were more in children (1,5). Ingestion of blunt foreign objects has been extensively discussed in the literature. Most (80 – 90%) ingested oesophageal foreign bodies that traverse the gastrooesophageal junction will pass through the gastrointestinal (GI) tract without complications. The risk of perforation is 1% for all types of ingested oesophageal foreign bodies (5,6).

Infants and toddlers do not have fully matured oesophageal coordination and often unintentionally swallow small, round foods such as grapes, peanuts and candies which may become impacted. In this case, the child ingested initially a metal object, which led to partial obstruction, but later on a baobab seed mixed with food materials worsened the symptoms to an extent that she would vomit everything after eating. However, these foreign bodies, though blunt, were not removed by spontaneously passing through the GI tract, requiring intervention.

In most of the cases, plain radiographs are diagnostic; however, in some cases they may not be sufficient. In such cases, upper Gastrointestinal (GI) endoscopy and CT scan can add some value (1). Dense foreign bodies

composed of metal may be readily seen on chest x-ray. Other foreign bodies may be radiolucent and invisible on x-ray (2). In this case, there was only one FB visible on the chest x-ray as a metal object, the other FB was incidentally found during procedure comprising of a baobab seed surrounded by food materials. The presence of the second FB was not suspected during clinical history and physical examination as it was not obvious and did not shown during imaging.

Most ingested foreign bodies are retained at the level of the cricopharyngeus muscle (upper oesophageal sphincter), about 15% at the level of the aortic arch at the mid-esophagus, and the rest at the level of the lower oesophageal sphincter (2). Both of the FBs in this case were found in the upper oesophagus.

CONCLUSION

Foreign body oesophagus is a common condition seen mostly in elderly and paediatric population. Although majority of the foreign bodies are said to pass spontaneously without the need of any intervention, every case should be treated as a medical emergency in order to avoid complications that may arise. Therefore, the mainstay of management is early diagnosis and removal of the FB.

Consent

Written informed consent was obtained from the parents for publication of this case report and accompanying images.

Competing Interest

The author declares no competing interests.

Author's Contribution

F.T.K was involved in patient care, drafting of the manuscript, literature review and critical revision of the manuscript.

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Abbreviations

FB –Foreign Body

GI – Gastrointestinal

NGT – Nasogastric Tube

REFERENCES

1. Shahi S, Bhandari TR, Thapa PB, Shrestha D, Shrestha K. Foreign body esophagus: Six years of silence. *SAGE Open Med Case Rep.* 2020 Jan;8.
2. Massawe ER, Richard Massawe E. TANZANIA MEDICAL JOURNAL Long Standing Foreign Body Oesophagus Masquerading Bronchial Pneumonia: A Case Report TANZANIA MEDICAL JOURNAL.
3. Li ZS, Sun ZX, Zou DW, Xu GM, Wu RP, Liao Z. Endoscopic management of foreign bodies in the upper-GI tract: experience with 1088 cases in China. *Gastrointest Endosc.* 2006 Oct;64(4):485–92.

4. Walton JM, Darr A, George A. An unusual case of an oesophageal foreign body presenting as torticollis. *Ann R Coll Surg Engl.* 2016;98(3):e40–2.
5. Chen T, Wu HF, Shi Q, Zhou PH, Chen SY, Xu MD, et al. Endoscopic management of impacted esophageal foreign bodies. *Diseases of the Esophagus.* 2013 Nov;26(8):799–806.
6. Zamyary KR, Davis JW, Ament EE, Dirks RC, Garry JE. This too shall pass: A study of ingested sharp foreign bodies. In: *Journal of Trauma and Acute Care Surgery.* Lippincott Williams and Wilkins; 2017. p. 150–5.