

## **Case Report**

### **Fish Bone Piercing Epiglottis: A Case Report**

*NH Nik Fariza<sup>1</sup>, M Irfan<sup>2</sup>, RR Ramiza<sup>3</sup>*

#### **Abstract**

Pharyngoesophageal fish bone is a commonly encountered ORL emergency. Usually the patient is able to point the most painful site to suggest location of the foreign body, immediately after ingestion. We report a patient with chronic, severe odynophagia which later on was found to have a fish bone piercing through epiglottis. The symptoms were present for more than 10 months before definite diagnosis was made and removal was done.

**Keywords:** Foreign body, Fish bone, Epiglottis.

#### **Case Report**

A 35 year old Malay female presented with odynophagia and dysphagia for ten months duration. She was only able to tolerate fluid within that period of time. She had visited multiple general practitioners and was treated as thyroiditis and pharyngitis. She lost ten kilograms during the course of illness. On further questioning, patient gave a distinct history of taking a bony fish prior to the onset of illness. She started to have severe odynophagia and dysphagia just after onset of the fish ingestion. She pointed the most painful area was at the central of thyroid cartilage. Otherwise she

had no history of fever, no change in voice and no neck swelling.

Laryngoscopic examination revealed a foreign body piercing the infrahyoid epiglottis. The fish bone was seen hanging in the supralaryngeal region (Figure 1). There was a thickened mucosa overlying the puncture site. Otherwise there was no pooling of saliva and no mass seen at the lingual part of epiglottis, base of tongue, valleculae, pyriform fossa and the posterior pharyngeal wall.



**Figure 1:** Laryngoscopic view of foreign body at the laryngeal surface of epiglottis.

Decision was made to remove the foreign body under local anaesthesia in the clinic. Patient's throat was then sprayed with 10% local anesthesia. The foreign body was removed under endoscopic vision. Minimal bleeding was noted from the puncture site. The fish bone removed was measuring 23 mm long (Figure 2).

Patient was discharged with a course of antibiotic. One week later on follow up, she claimed that she was able to take solid food since the day of the fish bone removed. Repeat laryngoscopic

1. \*Dr Nik Fariza Husna Nik Hassan,
2. Irfan Mohamad,
3. Ramiza RR,

Department of Otorhinolaryngology-Head & Neck Surgery, School of Medical Sciences, Universiti Sains Malaysia, 16150 Kota Bharu, Kelantan, Malaysia.

**\*Corresponds to:** Dr Nik Fariza Husna Nik Hassan, Department of Otorhinolaryngology-Head & Neck Surgery, School of Medical Sciences, Universiti Sains Malaysia, 16150 Kota Bharu, Kelantan, Malaysia.  
**Tel:** 609 7676428; **Email:** [nikfarizahusna@yahoo.com.my](mailto:nikfarizahusna@yahoo.com.my).



**Figure 2:** Fish bone which penetrated the epiglottis.

examination showed that the previous puncture site area was well healed with normal looking epiglottis, pharyngeal space, supraglottic and glottic region.

### **Discussion**

Foreign body in the aerodigestive tract is a common problem referred to ORL. The diagnosis is made by careful history with high index of suspicion. Odynophagia and inspiratory stridor are reliable signs of a foreign body in the pharyngoesophagus and tracheobronchial passage, respectively<sup>1</sup>. Our patient presented with severe odynophagia, and the diagnosis was missed and she had to bear with the symptoms for 10 months.

Upon history taking, she gave a clear history of severe odynophagia just after taking a bony fish. This is the most important part of the history that the diagnosis of fish bone ingestion should not be missed. Fish bone tends to be the commoner foreign body in Asia due to the practice of serving fish whole with the bones<sup>2</sup>. Fish bone foreign bodies

penetrating into the extrapharyngeal space are relatively rare, and most are identified in retropharyngeal soft tissues such as the peripharyngeal muscles, prevertebral space or prevertebral muscle<sup>3</sup>. In our patient, the fish bone was identified penetrating the epiglottic cartilage.

Epiglottis is a rare location for foreign body. With the sharp end of the foreign body in the laryngeal inlet, and the chronicity of the problem, most probably the foreign body was initially at the lingual surface of the epiglottis or at the base of tongue. With the movement of the base of tongue, the foreign body migrates to the laryngeal surface of epiglottis. Further migration of the fish bone, as in this case will lead to dislodgement into the airway.

Migrating foreign body can cause potentially fatal complications depending on the direction and site of the migration<sup>4</sup>. Fortunately, in our case, the penetrating fish bone still hanging on the supralaryngeal area. If it is dislodged, it may go into the airway causing a more sinister complication.

With the foreign body hanging in the laryngeal inlet, intubation was in question. Local anesthesia in fully cooperated patient was crucial for a successful per-oral removal. There was a risk of foreign body being dislodged or slipped into the airway during removal. However, uneventful office laryngeal foreign body removal can be expected provided the expertise of the treating and cooperation of the patient.

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