

# Foreign body in the larynx for 13 years

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## Abstract

**This is a report of case of an old man of 67 years who was fortunate to survive a foreign body (denture) into the larynx for 13 years. Fibreoptic endoscopy showed a whitish mass in between the cords; on removal by direct laryngoscopy it was found to be a denture.**

*Keywords: Foreign body, Larynx.*

## Introduction

Foreign body which is inhaled into the air passage seldom becomes impacted in the larynx, but passes through it into the trachea and bronchi. Impaction in the larynx is more liable to occur in children than in adult. Occasionally, in adult poorly masticated meat piece or denture may enter the larynx and be held there due to spasm of the muscles. In most cases of inhaled foreign body, there is a definite history of choking followed by paroxysmal coughing. After the initial paroxysm of coughing the tracheobronchial mucosa becomes tolerant of the foreign body and coughing ceases. This feature is often responsible for delay in diagnosis. Sudden onset of a wheeze in a child not

previously known to have asthma, should alert one to the possibility of a foreign body especially if the wheeze is predominantly unilateral.

## Report of a case

A 67-year old male visited the T.U. Teaching Hospital with a complaint of breathing difficulty and hoarseness for one month on 8/9/95. Emergency tracheostomy and direct laryngoscopy and biopsy were done. Direct laryngoscopy findings were proliferative growth involving left true cord and aryepiglottic fold. Left arytenoid was swollen with subglottic extension; left cord was fixed. Biopsy report showed acute and chronic inflammation and hyperplasia of squamous epithelium with moderate to severe dysplasia. Repeat biopsy was done, which again showed chronic inflammation.

X-ray soft tissue neck showed diffuse soft tissue shadow from the base of tongue to subglottis.

As the laryngeal growth did not subside with antibiotic the patient was put on antitubercular therapy as a therapeutic trial. The patient responded well to anti-tubercular therapy (ATT). Growth completely subsided after nine months of ATT. Fibreoptic endoscopy revealed whitish slough in between the cords which was hard in consistency.

Revaluation under general anaesthesia was done on 7/8/98. Direct laryngoscopy showed hard whitish mass in the subglottis, which was embedded in the granulation tissue. On removal it was found to be a denture. On eliciting the history properly, the patient informed that he had a history of ingestion of denture 13 years ago and had visited local hospital immediately. On examination the attending doctor could not find the denture and referred him to India for the treatment of cancer larynx, the patient was having pain in the throat,

mild dysphasia and occasional breathing difficulty all these years. On 6/5/95 he developed severe stridor and visited the T.U. Teaching Hospital. He had the impression that he had cancer larynx so he did not give the history of denture ingestion.

## Discussion

Foreign body lodging in the larynx that are completely obstructive usually cause sudden death. Objects that are only partially obstructing and thus compatible with life may cause hoarseness, croupy cough, aphonia, odynophasia, haemoptysis, wheezing and varying degrees of dyspnea. Foreign body airway obstruction should be considered in the differential diagnosis in any patient who suddenly becomes severely dyspnoeic, becomes cyanotic and falls unconscious for no apparent reason. If patient gives history of foreign body ingestion or aspiration, proper history taking is necessary regarding the duration, types of object, thorough clinical examination including auscultation of chest and trachea - we may hear an audible click due to movement of a foreign body up and down in the trachea. A unilateral expiration wheeze and reduced air entry may indicate a foreign body in the bronchus, if these findings are absent, a simple investigation like plane X-ray neck shows most of the radiopaque foreign body like meat bones, denture, coins. If it is missed in X-ray, we need to do fiberoptic endoscopy or rigid endoscopy to rule out foreign body or residual damage caused by foreign body.

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