

# ER Management of Ingested Foreign Bodies and Esophageal Food Boluses

Case 1 - "I ate it"

Case 2 - "I didn't eat it"

Case 3 - "I couldn't eat it"

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# Learning Objectives

- Describe the emergency department management of foreign body ingestion at our hospital
- Describe emergency department management of esophageal food boluses at our hospital

- No conflicts of Interest or Disclosures

# Case 1 - “I ate it”

- 20F lives in a group home with many visits for self harm and ingesting foreign bodies
- Pmhx
  - Developmental Delay, PTSD, Eating Disorder, Gender Dysphoria, Borderline Personality Disorder, Chronic abdominal pain, Migraines
- “Previous admissions for self harm behaviour have not been beneficial”

# Case 1 - “I ate it”

- 23:30 Triage Note:
  - “Cut self with utility knife then broke and swallowed the blade. Appears to be in little discomfort. In attempt to end life”
- Patient:
  - “I don’t know why”
  - No pain no vomiting
- Exam:
  - Abdomen is soft no focal tenderness to any palpation, vitals normal.

# Case 1 - “I ate it”

- Next Steps?

# Case 1 - “I ate it”

- Next Steps?
  - Labs - In otherwise asymptomatic individual no role
    - Beware congestion of toxins, Tylenol, etc.
  - Chest/Abdo XR



# Case 1 - “I ate it”

- Next Steps?
  - General Surgery

# Case 1 - “I ate it”

- Held overnight
- Reviewed with general surgery in the am
- Repeat XR 12 hours after ingestions showed still in the stomach
- Had endoscopy with manual retrieval and discharged to group home later that day

# Case 1 - “I ate it”

- Back in ER 2 days later with sharp foreign body ingestion...
- Discharged home as no abdominal pain.
- Passed with no complications at home.

# What does the evidence suggest?

- 80-90% of all foreign body ingestion will pass spontaneously
  - Sharp objects have risk of perforation of up to 35%
  - Endoscopic removal carries a risk of 6% chance of perforation, but also up to 30% risk of mucosal injury with deep lacerations and bleeding.

# What does the evidence suggest?

- Esophageal Sharp Foreign body
  - Immediate endoscopy
  - Call surgeon on call any time of day
  - If chest pain or short of breath or hematemesis then CT to clarify complications
    - If perforation will need thoracic surgery intervention

# What does the evidence suggest?

- Gastric Sharp Foreign body
  - Guidelines still suggest consideration for endoscopic removal is priority despite high rates of spontaneous passage
  - Call surgeon on call to review during reasonable hours
    - Likely to do serial XR, if hasn't passed the stomach in 12-24 hours may consider endoscopic removal

# What does the evidence suggest?

- Distal to Stomach Sharp Foreign body
  - Endoscopy not an option
  - Monitor for complications until spontaneous passage
  - Average transit time is 3.6 days
  - Mean time from ingestion to perforation is actually 10.4 days
  - Ileocecal region is the most common site of impaction now
  - Object length is the strongest predictor of required surgical intervention (5cm)
    - Other risks
      - Toothpicks, needles, animal bones
      - Previous abdominal surgery/adhesions



Operator:  
12/25







# Case 2 - “I didn’t eat it”

- 13F lives with mom
- PMHx anxiety, chronic abdominal pain, migraines
- Drive 2 hours to Huntsville for a second opinion on abdominal pain for 2 years
- Seen at 23:20

2 weeks no BM & vomiting. Not passing flatus. No relief restoralx & ducolax PR x 3. Not voided today. periumbilical abdo pain. Unable able to tolerate PO intake. D/c'ed sick kids

# Case 2 - “I didn’t eat it”

- Connecting Ontario

## **Most Responsible Diagnosis:**

*Somatic abdominal pain*

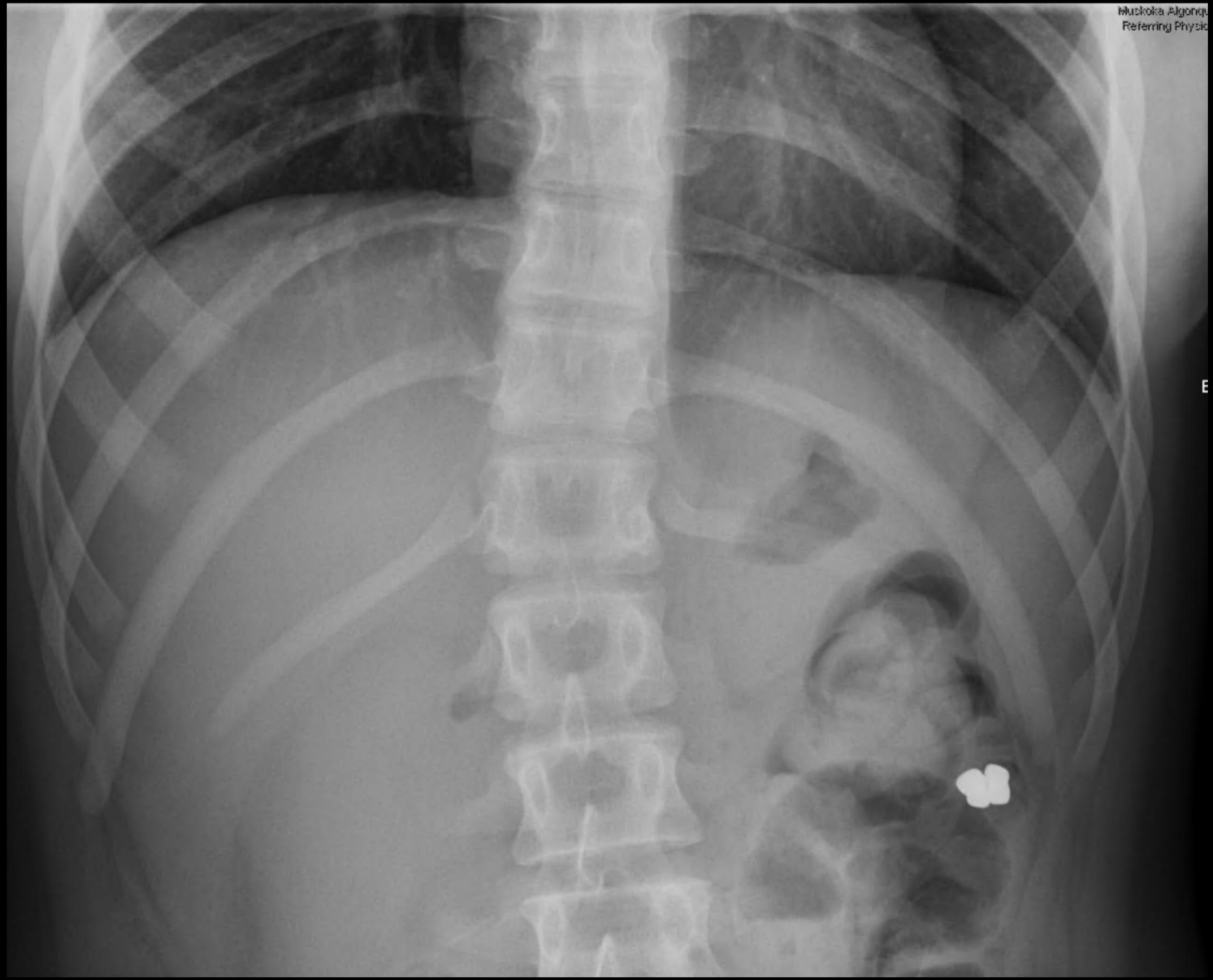
**Patient with a known somatic symptom disorder and appropriate follow-up in place closer to home. She is unlikely to benefit from further medicalization at this point. If she presents to the ED for decreased urine output, ensure she is adequately hydrated based on other clinical indicators and confirm urine production with bladder scanning. If clinically safe and appropriate, consider redirecting her back to her outpatient follow-up.**

# Case 2 - “I didn’t eat it”

- Diffuse mild abdominal pain on exam
- Main concern is no BM for 7 days
- Bladder scan 350cc and urinates in ER
- Denies any vomiting, hematochezia, gyne, or other symptoms

# Case 2 - “I didn’t eat it”

- Reassurance and review of recent Sick Kids notes
- Two admits there in the past month with no imaging (hx of imaging ++)
- Suggestion of not medicalizing
  
- Decided no labs but will XR



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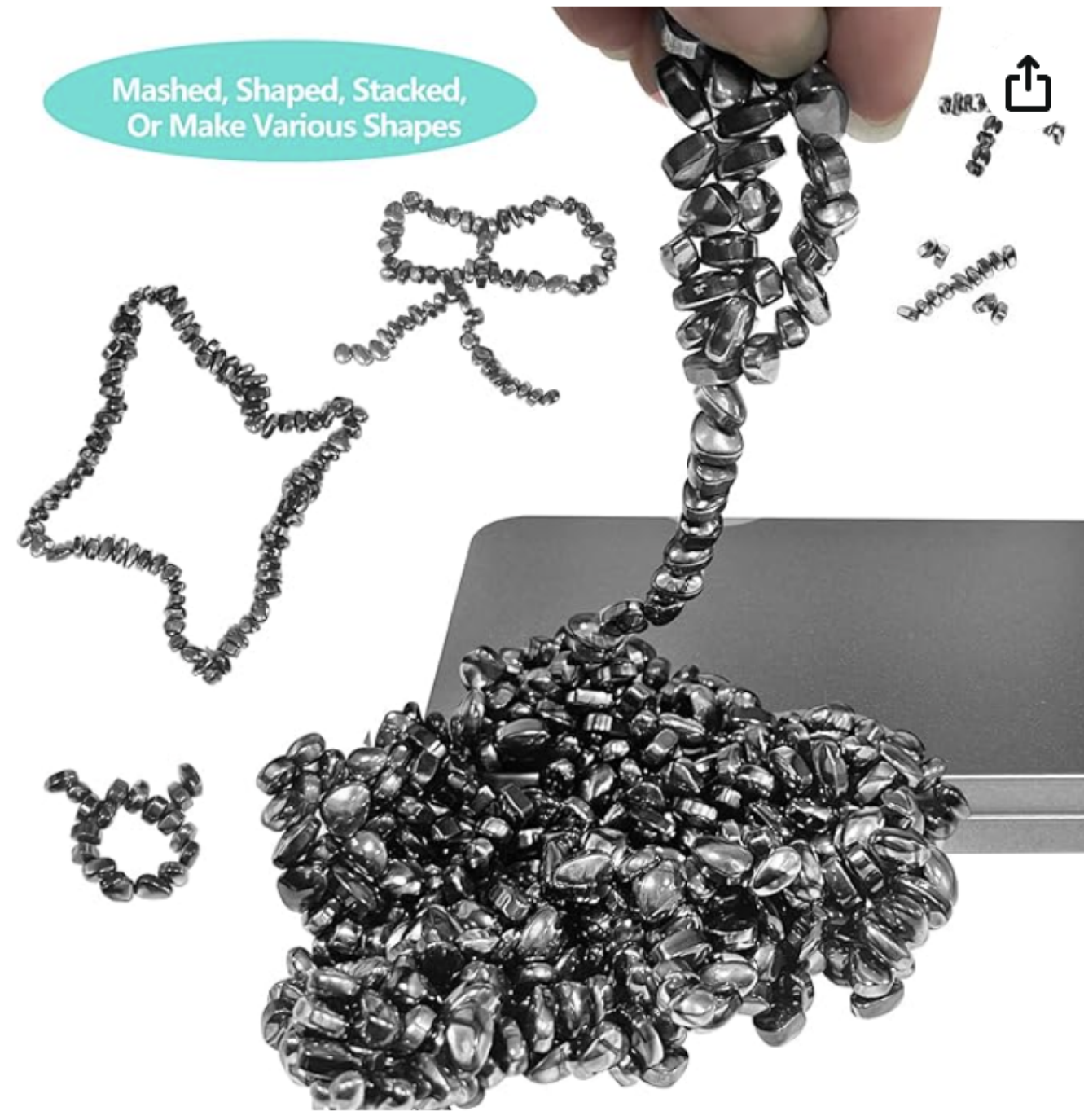


# Case 2 - “I didn’t eat it”

- Denies any ingestion, acts shocked
- Show patient and mom the XR
- Mom identifies magnetic beads and sewing needles that have gone missing from her bedside table



Mashed, Shaped, Stacked,  
Or Make Various Shapes



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Ask Rufus

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Can it be used for stress relief?

Is it portable?

Ask something else

# Ferrite Putty 510pcs, Magnetic Stones Fidget Toys Adults, Desk Fidgets Toys for Stress and Anxiety Relief and Kill Time, Novelty Adults Gifts Black

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# Case 2 - “I didn’t eat it”

- Review with radiology
- Call CT in
  - No perforation, no complication
- Review with Sick Kids
  - Accepts for transfer
  - Prior to transfer has bowel movement with sewing needle in stool

# Case 2 - “I didn’t eat it”

- Sick Kids
  - Some metallic FB’s already passed ileocecal valve
  - Whole bowel irrigation - PEG Lyte washout
  - Serial XR continued progression with eventual passing within 36 hours
  - Discharged 48 hours after admission

# Ingested Magnets

- Single - simple blunt foreign body
- Multiple - High risk with surgical intervention required in 59.1%
  - Perforation 44.3%
  - Intestinal Necrosis 19.3%
  - Peritonitis 12.6%
  - Septic Shock 4.5%
- Many patients asymptomatic initially, with delayed complications

# Ingested Magnets

- If beyond endoscopic reach:
  - Symptomatic
    - all need surgical exploration
  - Asymptomatic
    - serial inpatient XR and exams
    - If fail to rapidly progress needs surgical exploration
    - Whole bowel irrigation not recommended

# Case 3: “I couldn’t eat it”

- 45M to ER at 00:30
- Eating chicken with sudden discomfort to chest and inability to swallow secretions since 21:00
- No history of same
- Occasional heart burn
- No meds

# Case 3: “I couldn’t eat it”

- Next steps?

# Case 3: “I couldn’t eat it”

- Next steps?
  - XR?
  - Labs?
  - Interventions?

# Case 3: “I couldn’t eat it”

- Next steps?
  - XR?
    - Not mandatory in non bony food if no concern for perforation
  - Labs?
    - No role in stable patient

# Case 3: “I couldn’t eat it”

- Interventions?

# Case 3: “I couldn’t eat it”

- Glucagon 1mg IV
  - Relaxes lower esophageal sphincter
    - Not useful in eosinophilic esophagitis or structural abnormality
    - Only useful in lower esophageal spasm
  - Meta-analysis shows no more effective than placebo
  - Can be trialed while awaiting endoscopy, not delaying endoscopy
  - Small increased risk of aspiration due to vomiting

# Case 3: “I couldn’t eat it”

- Cola Beverage (or Prosecco/Champagne)
  - Releases CO<sub>2</sub> which distends the esophagus, increases intraluminal pressure proximal to bolus and propels it forward
  - Does not significantly improve resolution
  - Safe and inexpensive
  - Can be trialed while awaiting endoscopy, not delaying endoscopy

# Case 3: “I couldn’t eat it”

- Other
  - Nitrates, CCB, benzodiazepines all no better than placebo

# Case 3: “I couldn’t eat it”

- Endoscopy Guidelines
- Complete obstruction
  - Within 2-6 hours
- Partial Obstruction
  - Within 24 hours

# Case 3: “I couldn’t eat it”

- At MAHC if patient stable
- Daytime
  - Call general surgery upon patient presentation
  - Initiate Cola while waiting for OR setup in hopes of spontaneous passage
- Nighttime
  - Trial Cola and Glucagon
  - Call surgeon in am for endoscopy

# Case 3: “I couldn’t eat it”

- If food bolus spontaneously passes
  - Outpatient referral for endoscopy
  - Start PPI

# Case 3: “I couldn’t eat it”

- Meat 65%-85% - beef most common
- Soft meat bolus above a structural narrowing (schatzki ring or eosinophilic esophagitis)

# Take Homes

- Nighttime is a difficult time in particular with no in house imaging
- Have a high index of suspicion for half truths in mental health patients
- Dont be misdirected by previous assessment, give the patient the benefit of fresh eyes
- Chew your food
- Thanks to Hector Roldan for his advice