PAEDIATRIC ACUTE CARE GUIDELINE	
Inhaled Foreign Body	
Scope (Staff):	All Emergency Department Clinicians
Scope (Area):	Emergency Department

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http://kidshealthwa.com/about/disclaimer/

Inhaled Foreign Body

- If there is upper airway compromise, refer to choking child guideline

Assessment

History

- Sudden respiratory arrest and collapse is caused by complete obstruction of the upper airway by an inhaled foreign body.
- There may be a history of choking, gagging or coughing during eating or playing, and sometimes parents will recall seeing the child with something in their mouth before the event.
- Occasionally, children who were not previously suspected to have inhaled a foreign body may present to ED with persistent cough or wheezing.
- Pneumonia not responding to treatment or recurrent pneumonia in the same lobe / segment should raise concerns about an inhaled foreign body.

Examination

- Stridor indicates a partial obstruction of the upper airway by an inhaled foreign body
- Clinically there may be asymmetric chest movement and/or asymmetric breath sounds
- A foreign body acting as a ball valve may cause air trapping with subsequent hyperinflation of the particular lung/lobe and deviation of the trachea
- There may be localised wheezing, crackles or decreased breath sounds, or signs of consolidation suggesting collapse of a lobe/segment
- In some children there will be no abnormal findings

Investigation

- Radiological studies are **only indicated if there is doubt** regarding the presence of a foreign body.
- Children with history and examination findings suggestive of inhaled foreign body should be referred to the respiratory specialist (refer to Management)

If history and/or examination findings are inconclusive, imaging should be performed as follows:

- **In hours:** CT chest (request to state "?bronchial foreign body"). This is based on sensitivity and specificity approaching 100% with a radiation dose similar to conventional chest X-Ray.
- **After hours:** Inspiratory and expiratory PA chest X-Rays, plus a lateral chest X-Ray looking for:
  - An opaque foreign body may occasionally be seen. The lateral CXR will confirm its presence in the bronchial tree as opposed to the oesophagus.
  - Segmental or lobar collapse
  - Difference in lung expansion between the two sides
  - Localised hyperinflation or interstitial emphysema may result from a ball valve obstruction
  - Be aware that CXR may be normal

Management

For suspected upper airway foreign bodies

- Allow the child to sit upright in the position in which they are most comfortable
- If airway is compromised refer to Choking guideline
- Urgent referral to ENT

Indications for referral to respiratory medicine for suspected lower airway foreign bodies

Cases which meet **2 out of 3** of the following criteria:

1. Suggestive history and/or symptoms that could be explained by inhaled FB
2. Examination findings compatible with an inhaled FB
3. Radiological changes compatible with an inhaled FB

The respiratory team will contact ENT if a bronchoscopy is indicated.

Fast from time of clinical suspicion

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