Ashford and
St. Peter's Hospitals
NHS Foundation Trust

Paediatric Guideline:

Foreign Body Ingestion

History

Issue	Date Issued	Brief Summary of Change	Author
1	Dec 2018		
2			

For more information on the status of this document, please contact:	Dr E Dawson
Policy Author	Dr E Dawson
Department/Directorate	Women's Health and Paediatrics
Date of issue	Dec 2018
Review due	Dec 2023
Ratified	Nov 2018
Audience	Paediatric Department

Background

Children aged between 6 months and 4 years have the highest incidence of foreign body ingestion, though older children with mental health problems may ingest objects deliberately.

Any effects caused by ingestion, such as obstruction or impaction, will depend on the size, shape and composition of the object.

Key Points

The majority of foreign objects are low risk, and will not require imaging or intervention.

Button batteries and magnets are high risk and will need imaging.

Larger objects may cause complications and need surgical review.

Red Flags

Button batteries can erode through the oesophagus, so will need to be surgically removed urgently. Once in the battery is in the stomach it is benign.

Large objects >6cm long and/or wider than 2.5cm may get stuck in the pylorus

Magnet +metal object or > 1 magnet can cause potentially life threatening complications.

Lead based objects failing to pass through the stomach may cause acute systemic lead absorption.

Pre-existing GI abnormalities including previous surgery, TOF or stenosing lesions can lead to more complications than children with a normal GI tract.

Assessment

History:

Type of object and time of ingestion.

Identify potential of high risk object or child.

Coughing, drooling, pain on swallowing, reduced oral intake, abdominal pain or vomiting indicate probable obstruction.

Coughing, choking or respiratory distress makes inhalation more likely.

Examination:

ABC

Inspection of oropharynx for drooling, abrasions or lacerations.

Chest examination for unequal air entry or wheeze.

Abdominal examination for signs of peritonitis or obstruction.

Management:

Investigations

X-rays are not necessary in a well child with a normal GI tract, and a reliable history.

If suspected button battery, magnets or other high risk radio-opaque or unknown object in a high risk or symptomatic child, then x-rays will be necessary.

Most metals, except for aluminium are radio-opaque.

Treatment:

A child may be safely discharged without investigation or treatment if there is a reliable history of ingesting a low risk object and the child is asymptomatic. They should be advised to return if they develop breathing problems/abdominal pain or vomiting, fever or are unable to tolerate food or drink.

Interventions:

Objects impacted in the oropharynx require urgent ENT and anaesthetic assessment.

Button batteries lodged in the oesophagus need immediate removal by a paediatric surgeon.

Ingestion of multiple magnets +/- metal require endoscopic removal. One magnet on x-ray may actually be two stuck together.

Summary:

Only children with abnormal GI tracts, who have swallowed high risk objects and/or are symptomatic will need imaging.

Reference

Adapted from The Royal Children's Hospital Melbourne Foreign body ingestion guideline.