Aspiration of foreign body guideline

Obtain as clear a history as possible.
- Commonest between 6 months & 3 years
- Sudden onset of stridor/wheeze/choking/DIB/cough in a well child while eating or playing
- Parental suspicion that child has put something into mouth
If the history suggests FB inhalation, obtain CXR and discuss with ENT, even in the absence of any clinical findings.

Acutely unwell (obstruction most likely laryngeal/tracheal level)

Ineffective cough or unconscious

Follow choking child/ APLS algorithm.
Contact ENT urgently

Effective cough & conscious

Take to resuscitation area.

DONOTDISTRESSCHILD

Make them comfortable on parent’s knee. Apply monitoring & 02 if tolerated

Examination
- Cyanosis
- Croupy cough
- Tachypnoea
- +/- hyperventilation
- Transmitted noises

Call ENT & anaesthetic colleagues urgently

Transient symptoms. Initial cough, choking, wheeze.
Ensure thorough examination of mouth.

Ongoing cough +/- wheeze, purulent sputum in following days to weeks.

May resemble LRTI (usually upper lobe signs)
- Unilateral signs
- Crepitations, wheeze
- Bronchial breathing
- Decreased air entry and/or hyper resonance on affected side
- Temperature

Order chest X-ray including neck

Look for
- Unilateral Xray changes
- Radio opaque Foreign bodies (<20%)
- Hyper expansion of affected lobes +/- atelectasis
- Distal atelectasis (radiolucent foreign bodies)

CXR Changes seen

CXR NAD

Discuss with ENT

If history +/- clinical findings strongly suggestive of FB aspiration discuss with ENT. If discharging child without follow-up advise parents to return if child develops cough/temp/respiratory symptoms