

Hung W and Lin P² found, 76% and 24.7% FBs in food passage and air passage respectively while Brooks et al³ found it 80% and 20% respectively. In another large study 86.2% of FBs were in the pharyngo oesophageal region, while 13.7% in tracheobronchial region¹.

Amongst the cases of FB in the food passage, age ranged from 1 year to 65 years; however FB has also been reported⁴. In the literature, amongst infants oesophageal FBs are common especially in children. Most are ingested by children younger than 5 year with the peak incidence between 6 months to 3 years as a sequel to natural proclivity to put things in their mouth^{5,6,7}. We found our cases evenly spread over all age groups though they are marginally more below 5 years. 18 (62.06%) out of 29 FBs in food passage were found in cricopharynx; This was due to poor peristalsis, sphincteric action and narrow diameter. In one large series¹, 50.5% FBs in food passage were also seen in cricopharynx, thus supporting our observation. Similarly, in yet another study⁸, 83.5% of FBs were located at the cricopharynx.

We observed coin 12 (41.37%) followed by meat bone 7 (24.13%) to be the commonest type of FB in food passage. In a study of 152 cases (104 children and 48 adults), 91 FBs (69%) were coin; Kamat et al¹ found fish bone (39%) as the commonest FB. Geographical factors involved in the study (coastal area) may account for this difference in findings.

All our patients except 3 (10.34%) had radiological evidence of FBs. In these three patients FBs being radiolucent, thin barium was given and diagnosis were made after the Ba swallow. Kamat et al¹ observed that 81.2% had either direct or indirect evidence of FB. None of our patients developed complications; in one case stricture, aoesophagy, flexible oesphagoscopy was resorted and FB was partly removed and was partly pushed into the stomach.

FB in air passage:

Youngest patient was 1 year old while oldest was 40 years. Relatively smaller number of patients limit our ability to comprehensively compare it with other studies.

In 4 (50%) patients FBs were encountered in the right bronchus, whereas in 2 (25%) patients they were in the left bronchus. In a study where 42 patients were studied, 25 FBs were in the right main bronchus and 17 in left main bronchus, thus supporting the

conventional observation that right bronchus being larger and straighter, invite FB more frequently. In 6 patients (75%) nature of FB was seed. Bhalodia et al⁹ found vegetable FB, mostly seed (ground nut) in 38 out of 42 patients, which is in keeping with our observation. None of our patients with FB in airway had evidence of FB (direct or indirect) and only after bronchoscopy FBs were revealed and removed.

Cases with suspected FB in tracheo bronchial tree can present with normal auscultatory and/or X-ray chest findings. A definitive or suspicious history of FB inhalation should be the most important factor in deciding for bronchoscopy in these patients. Performing an X-ray chest in these patients at the time of presentation has only a limited value in diagnosis and should never influence the decision for a timely bronchoscopy. Bhalodiya et al found normal X-ray finding in 32 out of 42 patients. They also observed that the time elapsed since inhalation was significantly related to normalcy of X-ray chest findings. None of our patients including one who had ASD, congenital heart disease developed any complications.

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