

## Ingestion of Foreign Body – Level II

### INGESTION of FOREIGN BODY

Level II  
(No Level I)

**Skill Level:** RN /LPN

**Definition:** A wide variety of Foreign objects are ingested by patients, which may be aspirated or swallowed. The majority (80% to 90%) of gastrointestinal foreign bodies will pass through the gastrointestinal (GI) tract without any clinical sequelae and cause no harm to the patient. Foreign objects in the esophagus generally have the highest incidence of overall adverse events, with the complication rate being directly proportional to how long the object is lodged in the esophagus. Once a FB passes through the esophagus, the vast majority will pass through the rest of the entire GI tract without further difficulty or complication. Aspiration, perforation, and bleeding laceration are complications.

<p><b>Subjective:</b></p> <ul style="list-style-type: none"><li>• "I swallowed my – pen, fork, razor, battery, coin, earphones, etc."</li><li>• Ingestion may be intentional or accidental.</li></ul>	<p><b>Assessment:</b></p> <ul style="list-style-type: none"><li>• Alteration in comfort ingested foreign object.</li><li>• Risk for Aspiration.</li><li>• Risk for GI distress, including bowel perforation.</li></ul>
<p><b>Objective:</b></p> <ul style="list-style-type: none"><li>• No Airway compromise, no choking, no obstruction</li><li>• No respiratory distress or breathing compromise.</li><li>• Speech quality normal.</li><li>• Able to swallow own saliva or other fluids.</li><li>• No acute abdominal pain with guarding or rebound.</li><li>• No active bleeding from a source that you cannot directly see to control as needed.</li><li>• Ingestion of a non-food item that might pose a risk to the patient.</li></ul>	<p><b>Plan:</b></p> <p><b><u>Emergent/Urgent transport for any of the following:</u></b></p> <ul style="list-style-type: none"><li>• Patient choking, gasping, or unable to speak. (Attempt abdominal thrust maneuver if patient is unable to speak. See nursing education.)</li><li>• Patient drooling and/or unable to swallow own saliva.</li><li>• Loss of consciousness.</li><li>• Patient vital signs unstable (BP&lt;90 systolic, P&gt;120, T&gt;101) (evidence of sepsis or cardiovascular collapse.)</li><li>• Acute abdominal pain with evidence of perforation.</li><li>• Active bleeding from a source that you cannot directly see for control.</li></ul> <p><b><u>Discuss with medical provider if possible, but do not delay transport.</u></b></p> <p><b><u>Not emergent or urgent: Call Provider</u></b> Review the following for discussion with the provider:</p> <ul style="list-style-type: none"><li>• Record patient statement of reason for ingestion</li><li>• Oropharyngeal exam</li><li>• Airway status and Respiratory status</li><li>• Ability to speak and quality of voice</li><li>• Ability to swallow own secretions and other liquids</li><li>• Neck and chest examination for subcutaneous crepitus, erythema, or swelling, and breath sounds in all lobes.</li><li>• Any blood or bleeding.</li><li>• Length of time since ingestion</li></ul>

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	<ul style="list-style-type: none"><li>• Abdominal exam for signs of perforation, obstruction, guarding or rebound, extreme tenderness.</li><li>• Description of ingested object, esp.; length longer objects (&gt;6cm), width (&gt;2.5cm), sharp or pointed projections, caustic batteries, magnets, toxics, etc.</li></ul> <p><b><u>Obtain monitoring and treatment plan from provider.</u></b></p> <p><b><u>Possibilities:</u></b></p> <ul style="list-style-type: none"><li>• Usually obtain an X-ray of Abdomen or Chest within 24 hours to evaluate number and location of object(s).</li><li>• If patient is stable with no worrisome factors, get daily nursing checks</li><li>• Repeated chest/abdomen films are useful to document progression of objects not removed.</li><li>• Consider provider visit next available time.</li><li>• Consider mental health evaluation if ingestion was intentional.</li></ul>
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### **Nursing Education**

1. “Heimlich Maneuver” is no longer suggested. Do an emergency abdominal thrust to attempt to dislodge a foreign body in the hypopharynx if the patient is unable to speak. If the patient is morbidly obese or pregnant, do a chest thrust, not an abdominal thrust.
2. The majority (80% to 90%) of gastrointestinal foreign bodies (FB) will pass through the gastrointestinal (GI) tract without any clinical sequelae and cause no harm to the patient.
3. Foreign objects in the esophagus generally have the highest incidence of overall adverse events, with the complication rate being directly related to the length of time the object is lodged in the esophagus. Risk is highest in the esophagus, lower in the stomach and lower still distal to the stomach.
4. Once a FB passes through the esophagus, the vast majority will pass through the rest of the entire GI tract without further difficulty or complication. Once in the small intestine and colon, most objects, even sharp ones, rarely cause damage because the bowel naturally protects itself through peristalsis and axial flow; these tend to keep the foreign body concentrated in the center of fecal residue, with the blunt end leading and the sharp end trailing.
5. Complications are more apt to occur in areas of natural narrowing, angulation, anatomic sphincters, or at strictures of previous surgery.
6. Caustic batteries, magnets, sharp edged/pointed objects, especially if lodged in the esophagus, present with higher consideration for prompt removal.
7. Objects still in the esophagus (above the diaphragm) more than 12 hours should be considered for endoscopy. Objects should not remain in the esophagus longer than 24 hours even in a stable patient.

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8. Objects still in the stomach greater than 3 days should be considered for endoscopic removal.
9. Patients with complex, large, sharp, objects in the intestines should have an abdominal exam daily for signs of perforation, obstruction, peritonitis, infection, until object has passed.
10. Imaging such as computed tomography (CT) or magnetic resonance imaging (MRI) rarely is needed for the diagnosis of foreign objects.
11. Disc (button) batteries in the esophagus should be removed. Once in the stomach or intestines, they rarely cause problems. These patients can be observed. Multiple magnets or magnets with other metallic objects pose special problems in the intestines and should be removed if possible from the stomach by endoscopy before they pass to the small intestine.

### APPROVED:

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Medical Services Manager

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Date

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Chief Medical Officer

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Date

*Steve Shelton M.D.*

*2/24/2015*

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Medical Director

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Date

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