Fish Bone Ingestion Presenting As Acute Retropharyngeal Abscess – A Case Report

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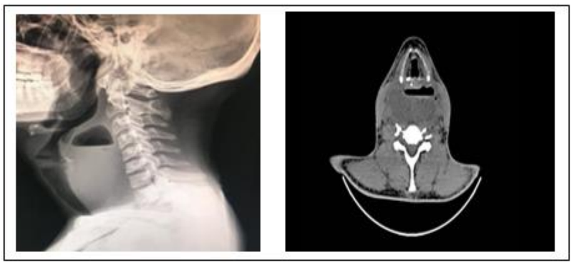
INTRODUCTION

A retropharyngeal abscess is an infection with abscess collection in one of the deep spaces of the neck [1]. Retropharyngeal abscess is an uncommon but potentially life-threatening diagnosis [2]. Patients with diabetes and those who are debilitated, older adults or immunocompromised patients are more likely to get this infection [3]. This disease is most common in children [4] under the age of five but also occurs in adults. There has been a gradual shift in this disease from children below 6 years of age to older children and adults [5]. In adults, a retropharyngeal abscess can be caused by cold abscess, foreign body ingestion [6] or trauma to the posterior pharynx, which leads to inoculation of the retropharyngeal space and results in abscess formation. As a retropharyngeal abscess grows in size, it can lead to upper airway obstruction and asphyxiation. Treatment of retropharyngeal abscess includes intravenous antibiotics along with surgical incision and drainage.

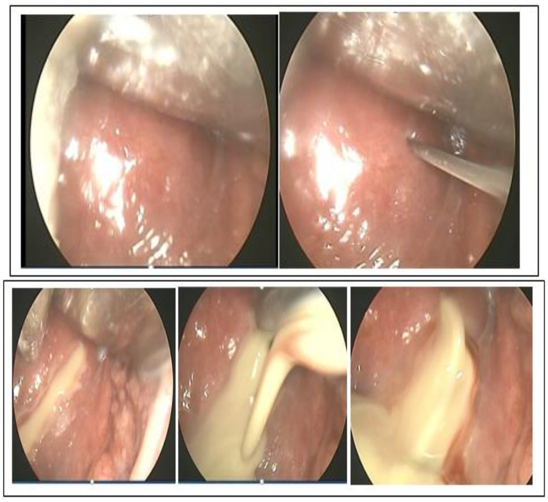
CASE REPORT

A 35-year-old male presented in ENT OPD with history fish bone ingestion presented with complaints of progressive odynophagia, Dysphagia and swelling in lateral neck region since 8 days. Patient had no known comorbidity. On examination patient was afebrile with normal vital parameters. Otorhinolaryngology evaluation revealed a diffuse neck swelling involving right lateral side of neck and extending superiorly from level of mandible to Inferiorly up to clavicle. Swelling was firm in consistency, tender, mobile, raised local temperature. Examination of oral cavity and oropharynx revealed satisfactory dental hygiene with adequate mouth opening. Bulging of posterior pharyngeal wall could be seen.

On Investigating, the plain radiograph neck lateral view shows air in the retropharyngeal space which is specific for retropharyngeal abscess. CECT neck and chest was requested which revealed heterogeneously enhancing collection involving the retropharyngeal space.



The patient was resuscitated with intravenous fluid and antibiotics and was taken for examination under anaesthesia and drainage of the abscess. Tracheostomy was performed prior for securing the airway and then incision and drainage of the abscess was done. Intraoperatively dark yellowish pus was drained from the retropharyngeal space. Ryle tube was placed after procedure was completed. Pus sent for culture and sensitivity which showed no growth of organsims.



<u>Post-op neck lateral view-</u>

Repeat lateral neck radiogram on post op day 2 and 5 were performed.

<u>POST OP VIDEOLARYNGOSCOPY:</u>

DISCUSSION:

The retropharyngeal space is a potential space which lies between the visceral (buccopharyngeal) fascia covering the posterior pharynx and oesophagus and the alar fascia [7]. It extends from the base of the skull down into the superior mediastinum, where the visceral and alar fascia fuses at the level of the second thoracic vertebra. Laterally, it is bounded by the carotid sheath. Acute retropharyngeal abscess may be seen both in children and adults following trauma to the posterior pharynx with secondary infection.

Retropharyngeal abscess is not common nowadays with the increasing use of antibiotics in the treatment of upper respiratory tract infections. It is almost exclusively a pediatric diagnosis. Most incidents occur in children ages six months to six years [8] in whom the index case still falls within a mean age of three to four years.

de Clercq LD et al in its paper on retropharyngeal abscess in adults have stated that patients usually present with fever, odynophagia, dysphagia, dyspnoea, drooling, cervical rigidity (torticollis), a 'hot potato' or hyponasal voice, and sepsis [9].

The causative organism can vary depending on the source of infection. Most cases are polymicrobial and involve both aerobes and anaerobes [10].

In our case report, in the absence of a positive culture report the management should include aggressive broad spectrum injectable antibiotics.

CECT of the head and neck is the radiological investigation of choice to confirm the diagnosis and evaluate for spread of infection into adjacent deep neck spaces [11]. Other radiological investigations include plain radiograph, ultrasonography (USG) and magnetic resonance imaging. USG is especially useful because of its easy availability, bedside procedure, guided aspiration of pus, and avoids radiation exposure and repeat follow up imaging.

Surgical intervention is the mainstay of treatment for more complicated or severe cases of deep neck space infection. Indications for surgery include airway compromise, critical condition, septicemia, complications, descending infection, diabetes mellitus, or no clinical improvement within 48 hours of the initiation of parenteral antibiotics [12]. Abscesses greater than 3 cm in diameter that involve the prevertebral, anterior visceral, or carotid spaces, or that involve more than two spaces, should be surgically drained. Surgical drainage can be performed in several ways, including simple intraoral or extraoral incision and drainage for superficial abscesses, a more extensive external cervical approach for deeper and more complicated infections [7]. Large and multilocular abscesses usually require incision and drainage. In our case report, prior drainage, tracheostomy was planned. Wide exposure of the infected tissue is important, as is debridement of any necrotic tissue that is present. Wounds with less necrosis can be closed at surgery with active suction drainage

CONCLUSION-

The purpose of this case is to lay emphasis on diagnosis of retropharyngeal abscess or certain inflammatory conditions in patient coming with the short history of dysphagia or dyspnea. Retropharyngeal abscess requires thorough examination as well as fast decisions like we took, Patient's short history of neck swelling was pointing towards a diagnosis which was not carcinoma but was definitely sinister. We went for video laryngoscopy and found the bulge. This paved the way for Xray and CT scan in which we were able to grab the diagnosis. Thereafter, we quickly drained the abscess but not before taking the wise decision of tracheostomy rather than the usual intubation, helping in the best treatment of the patient. So, a patient giving short history of dysphagia along with dyspnoea should always be looked for retropharyngeal space for abscess formation in the first visit itself. Successful outcomes depend on early identification and urgent aggressive management [13]. The main highlight of the management should be to secure the airway along with evacuation of the pus by surgical drainage and aggressive intravenous antibiotic therapy which should preferable is culture directed.

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