PREOPERATIVE DIAGNOSIS: , Esophageal foreign body.,POSTOPERATIVE DIAGNOSIS:, Esophageal foreign body.,PROCEDURES PERFORMED:,1. Direct laryngoscopy with intubation by surgeon.,2. Rigid tracheoscopy.,3. Rigid esophagoscopy with removal of foreign body.,INDICATIONS: , The patient is an 8-month-old Hispanic male, who presented to the Emergency Department with approximately 12-hour history of choking event and presumed for esophageal foreign body. When seen in the Emergency Department, he was having no difficulty managing his secretions or any signs of any airway compromise. Imaging in the Emergency Department did demonstrate an esophageal foreign body at or above the level of the cricopharyngeus. Due to this, the patient was consented and taken urgently to the operating room for removal of this foreign body.,OPERATIVE DETAILS:, The patient was correctly identified in the preop holding area and brought to operating room #37. After informed consent was reviewed, general anesthesia was induced, initially with propofol, the existing IV. Following this after protective eye tape was placed, #9 Parson's laryngoscope was introduced transorally and used to perform a direct laryngoscopy. Normal anatomy was visualized. Following this, a 4-mm, 20-rigid endoscope was introduced through the Parson's laryngoscope and used to perform a direct tracheoscopy. The patient's supraglottis, glottis, and subglottis down to the level of the mid trachea were found to be benign with no abnormal-appearing anatomy. Following this, the rigid endoscope was removed and the patient was

intubated with a 4-0 endotracheal tube cuffed without difficulty. After confirming bilateral breath sounds and positive end tidal CO2, this was secured to the patient by the anesthesia staff. Following this, the Parson's laryngoscope was removed and a size 4 rigid esophagoscope was inserted transorally and passed down to the level of the patient's cricopharyngeus were the foreign body was visualized. At this point, the coin grasper device was connected to the camera system and inserted through the existing esophagoscope. This was used to grasp the coin and the coin was removed under direct visualization and handed off as a separate specimen. Following this, the 34 mm 0-degree scope was inserted through the esophagoscope once the esophagoscope was passed down to the patient's GE junction. The entire esophageal mucosa was examined as the esophagoscope was backed out and there was only a minimal amount of superficial ulceration in the posterior wall of the esophagus near the level of the cricopharyngeus muscle. There were no other lesions or signs of further esophageal damage. Following this, all instrumentation was removed, and care of the patient was turned back to the anesthesia staff for stable wakeup.,FINDINGS:,1. Normal supraglottic, glottic, and subglottic anatomy.,2. Esophageal foreign body at the level of the cricopharyngeus.,COMPLICATIONS:, None.,ESTIMATED BLOOD LOSS:, None.,DISPOSITION: , Stable to the PACU and then home.