

LETTER TO EDITOR (VIEWERS CHOICE)

MAGNETIC BEADS - HAZARDOUS BEAUTY

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A 26 months old boy was referred from the emergency department with sudden onset dysphagia and excessive drooling of saliva while playing with magnetic beads. He was playing with his older sibling without adult supervision. On examination, he appeared uncomfortable with drooling of saliva. There was no stridor, cyanosis or palpable neck mass. A lateral and anteroposterior neck radiograph was performed (Fig 1A, 1B) prior to examination of the patient which showed 3 magnetic beads at the level of C2. Intraoral examination showed one magnetic bead of size 0.5 cm seen at the base of the uvula anteriorly and sandwiched with another 2 beads at the left superior pole of the tonsil posteriorly. Bedside flexible nasendoscopy findings revealed magnetic beads at the soft palate region. Foreign body was removed at the bedside using Tilley's forceps (Fig 2). The procedure was uneventful.

Figure 1 (A). Lateral neck radiograph showing 3 round opacities foreign body at level of C2.



(B) AP neck radiograph with 3 round opacities foreign body in the oropharynx

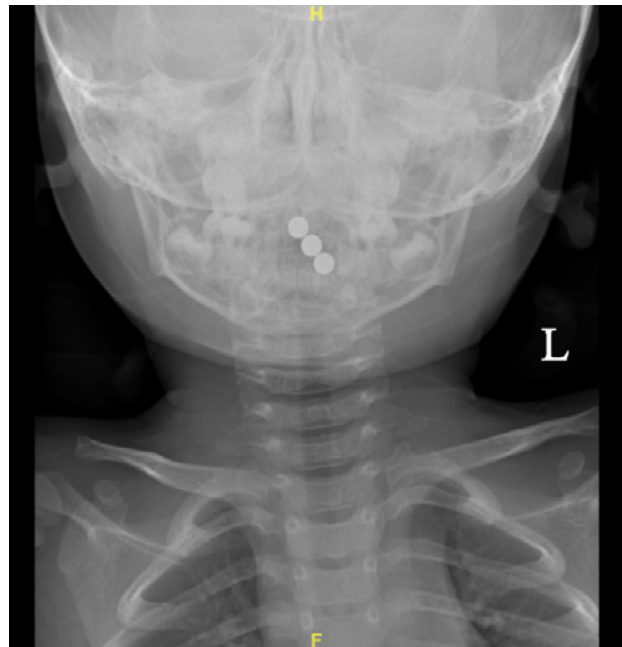


Figure 2. Magnetic beads post removal from oral cavity



Ingestion of magnetic beads in children has been increasingly reported lately due to its attractiveness. Most cases presented with ingestion in the gastrointestinal system^{1,2} and rarely stuck in the oral

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cavity. Management of foreign body in the oral cavity is mostly simple and can be performed in a clinic setting. In this case, we use Tilley's forceps (metal) to grab one of the beads that was located at the base of the uvula. Using metal instruments or magnets for removal of magnetic beads in the oral cavity is helpful as the magnetic force will attract the other beads for complete removal. However, precautions need to be taken as a foreign body can dislodge in the airway causing partial or complete airway obstruction especially due to the small airway calibre in children. Dislodged magnetic beads can cause a wide range of bowel damage, including perforation, intestinal fistula and asymptomatic obstruction leading to bowel ischemia.¹ Consequently, delayed presentation and diagnosis will probably result in more extensive bowel resection.¹ Essentially, a high index of suspicion with sudden onset of unexplained symptoms in a healthy

child and early intervention of foreign body removal is crucial to reduce morbidity and mortality in the pediatric age group.

Compliance with Ethical Standards

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Conflict of Interest: None

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