



Aspiration of a dental bridge: case report or diagnostic challenge

Bir diş köprü Aspirasyon : Olgu sunumu veya teşhis meydan

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Abstract

Foreign body aspiration is a worldwide health problem that often results in life threatening complications. Accidental aspiration of metal ceramic bridge (MCB) is not uncommon, but has not been reported frequently in the literature. Dental treatment procedures, impaired cough reflex, epileptic seizure, intubation procedures during resuscitation and maxillofacial trauma are the main reasons for accidental aspiration.

Airway foreign bodies can become lodged in the larynx, trachea, and bronchus. The earliest symptoms that commonly appear during aspiration include coughing, choking and wheezing including long-term complications, such as lung abscess and pneumonia, too. A 73-year-old Macedonian female with a past medical history of hypertension, chronic obstructive bronchitis, diabetes and epilepsy due to acute onset of incessant cough, dyspnea and an inspiratory and expiratory wheeze, apparently obstructive, was brought to the internal medicine emergency ambulance. Auscultation finding showed right sided weakened vesicular breathing, which closely mimic an acute asthma exacerbation. After conducted chest radiography, radiologist described metallic foreign body (MFB) in the right bronchus and soft transparency difference between left and right lungs. For better visibility of MFB and its position in the lung, a computed tomographic (CT) scan was done which confirmed its position in the right lower lobe bronchus near its origin. Foreign body forceps was inserted and this MFB was grasped and withdrawn. It was found to be inhaled MCB with 4-unit crown. After the bronchoscopy intervention, the control rentgenography and the gas analysis (pO₂ and pCO₂) didn't show any pathological findings. Quick and timely appropriate intervention by bronchoscopy removal saved the patients from extensive reconstructive surgery.

Key words: *Foreign body aspiration, metal ceramic bridge, radiography, bronchoscopy*

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INTRODUCTION

Accidental aspiration of dental prostheses, partial dentures or metal ceramic bridge (MCB) are not uncommon, but has not been reported frequently in the literature. An electronic search under the term "inhaled metal ceramic bridge" yielded zero references. After removing the quotes, search with the same term as a keyword showed more results but most of the cases represented to us were cases with swallowed dentures. Selective search on "google scholar" instead on "google", with abbreviated term "inhaled dental bridge" showed only six references including this issue. The small number of obtained references in the field of inhaled foreign bodies encouraged me to show an interesting case of accidental MCB inhalation in elderly woman.

As the population of the world ages, the need to provide patients with tooth replacement through removable partial dentures or MCB is correspondingly increasing. Movement of the denture in and out of the mouth will be a routine performed daily. Using sectional or poorly designed partial dentures or MCB has led to the unexpected accident of denture swallowing or inhaled. The location of a swallowed or aspirated dental prosthesis and MCB often is accomplished radiographically, but this is difficult with prostheses constructed entirely of acrylic resins. Poly (methylmethacrylate), the plastic from which most dentures are made, is radiolucent (almost entirely invisible in x-ray photographs). Porcelain teeth produce light shadows on a plain radiograph but it is the metal pins attaching the teeth to the denture base that make them readily discernible. Although a plain X-ray may well not identify a swallowed or inhaled denture, the investigation has been recommended to exclude pneumomediastinum or gas within the soft tissues. A soft-tissue exposure is more likely to suggest the presence of a plastic denture than a standard exposure (1).

In adults, aspiration of teeth and dental restorations is a recognized, yet an infrequent happening in the literature (2). Main reasons for aspiration are maxillofacial trauma, dental treatment procedures, ethanol intoxication, impaired cough reflex, intubation procedures during resuscitation and dementia (3, 4). Antipsychotics, anticholinergics and anxiolytics can impair the cough reflex, too (4). Tachypnoea, resulting from various medical conditions, alters the coordination between deglutition and respiration, and increases the risk of aspiration.

Available literature recognizes that impaction of aspirated objects occurred in 56% of instances within the right lower lobe and 33% in the left lower lobe (5). In the series reported by Debeljak et al (6) forty-two foreign bodies were in the right endobronchial tree, twenty were in the left, and one was in the trachea. Once aspirated, objects may subsequently change position or migrate distally, particularly after unsuccessful attempts to remove the object or if the object fragments.

Ingestion occurs more often than aspiration and usually does not cause any clinical signs or symptoms as it is spontaneously rejected from the gastrointestinal tract in most of the cases. However, aspiration always requires specific treatment since the foreign body may cause severe obstruction and can become life threatening (7). Airway foreign bodies can become lodged in the larynx, trachea, and bronchus. The size and shape of the object determines the site of obstruction. The large, round, or expandable objects produce complete obstruction, and irregularly shaped objects allow air passage around the object (inhaled partial dentures or MCBs) resulting in incomplete obstruction. In general, aspiration of foreign bodies produces the following 3 phases: *first or initial stage* shows choking, gagging and paroxysms of coughing, obstruction of the airway, occurring at the time of aspiration;

Second stage or asymptomatic phase: these signs calm down when the foreign bodies lodges and the reflex grow weary and *third stage* (also defined as complication phase) when the obstruction, erosion or infection cause pneumonia, atelectasis, abscess or fever (8). The earliest symptoms that commonly appear during aspiration include coughing, choking and wheezing. Even if the airway does not appear to be immediate jeopardy, possible early complications of foreign body aspiration may occur including dyspnoea, laryngeal edema, perforation and pneumothorax. Long-term complications, such as lung abscess and pneumonia, may also develop (9, 10). The purpose of this case report is to describe an unusual case of aspiration of MCB and its nonsurgical retrieval. It also emphasizes that fast and accurate diagnosis with adequate early treatment, results in a safe outcome for the patient.

CASE REPORT

A 73-year-old Macedonian female with a past medical history of hypertension, chronic obstructive bronchitis, diabetes and epilepsy was brought to the emergency room due to acute onset of incessant cough of a spasmodic nature, dyspnea, breathlessness, chest pain and an inspiratory and expiratory wheeze, apparently obstructive. Upon arrival to the emergency ambulatory of internal medicine, she was saturating 95 percent on room air and all vital signs were within normal range. A physical examination was significant for decreased air entry on the right lung side. Auscultation finding showed right sided weakened vesicular breathing, which included scattered rhonchi, and wheezing. These closely mimic an acute asthma exacerbation.

We revealed: heart rate 110 b/s, respiration rate 38 r/s with signs of accessory muscle use, decreased breath sounds with inspiratory and expiratory wheezing and patient was coughing up small amounts of white sputum. An arterial blood gas (ABG) analysis showed the following results: pH 7.45, PaCO₂ 32.1 mmHg and PaO₂ 70.2 mmHg. After intravenous administration of bronchodilators, corticosteroids and inhaled anticholinergic, the condition was not significantly improved.

Auscultation differences between respiration of both lungs and ABG analysis indicate radiographic imaging of the lung, under suspicion for acute obstruction of respiratory tract. After conducted chest radiography, radiologist describes MFB in the right bronchus and soft transparency difference between left and right lung (Fig. 1).



Fig. 1: Chest radiograph shows metal ceramic bridge (4-unit crowns) lodged in the right mainstream bronchus (anteroposterior view of x-ray)

Better visibility of the foreign body was acquired by right-sided lateral view chest radiograph, which was made immediately after the first chest radiograph developing. At first sight of lateral radiograph, we do not recognize the nature of the metal shade located longitudinally in the right bronchus. After right clockwise radiograph rotation we noted that it is a dental creature, exactly, 4-unit crowns metal bridge (Fig. 2).



Fig. 2: Chest lateral view radiograph shows metal ceramic bridge (4-unit crowns) lodged in the right lung

High x-ray decreased transparency (hypolucencie) in right lung is visible as result of proximal bronchial foreign body obstruction, occurred because of less lung air content. For accurately verify MCB position in the lung, a computed tomographic (CT) scan was done to confirm its position in the right lower lobe bronchus near its origin (Fig. 3). Aspirated foreign body was lodged in the right main stem bronchus, on 7.8cm distance from the tracheal bifurcation, 1.5cm distantly from middle lobe branches (on the transitional boundary between the right middle and right lower lobe).

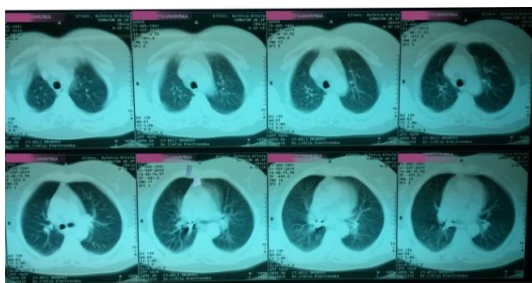


Fig. 3: CT scan (sliced layer-by-layer) of upper thorax shows inhaled metal ceramic bridge (4-unit crowns) lodged in the right mainstream bronchus

Before inserting flexible optical fiberscope (Olympus BF P-10, pulmonary insertion tube 5.0 mm, biopsy channel 2.0 mm, working length 55 cm) transorally, we administrate premedication of intramuscular atropine sulfate 1 mg, midazolam and pethidine and we gave topical anesthesia of the upper and lower airways consisted of 2% and 0.5% lidocaine, respectively. Foreign body forceps was inserted and this MCB was grasped and withdrawn together with the bronchoscope. It was found to be inhaled MCB with 4-unit crown, presented in figure 4. The size of retrieved foreign body was: 26.3 x 8.2 x 6.3 mm.



Fig. 4: Retrieved aspirated metal ceramic bridge

DISCUSSION

Moreover, patients who have inhaled a foreign body, fail to improve with conventional bronchodilators. However, the absence of atopy, the acute onset of symptoms, and unilateral physical findings may suggest foreign-body aspiration. Thus, clinical suspicion is crucial in the diagnostic process.

The history showed that the patients had primary epilepsy for seven years, diagnosed as generalized tonic-clonic type with a frequency of four or more attacks per year. During the clonic phase the tongue or cheek can be bitten and frothy and bloody saliva may be expectorated from the mouth. Displacements of prosthesis increase the risk for possible aspiration of the prosthesis into the upper respiratory tract. Although the patient had no memory of the incident about how she inhaled the dental bridge, the symptoms of wheezing and history for epilepsy headed to doubt about the inhalation of a

foreign body in the course of last epileptic seizure.

Zitzmann et al. (2000) suggest that if the aspirated or ingested foreign body cannot be coughed out, it is mandatory to take frontal and lateral chest radiographs to identify the objects position in the intestinal system or the tracheobronchial tree (11). It should be ensured that airway is not obstructed and the patient is informed about the problem. The patient was very surprised when told to her that her dental bridge was inhaled in her airway. She confirmed the lack of her dental bridge that happened a day before during an epileptic seizure.

Acute obstruction can be life threatening and delaying the removal of foreign objects may make a bronchoscopy technically more difficult. Fiber optic is a preferable option in contrast to rigid bronchoscopy in the case of a distally wedged foreign body. The flexible bronchoscope can provide access to subsegmental bronchi beyond that provided by the rigid bronchoscope. If gas exchange is already compromised or if insertion of the flexible bronchoscope would result in significant impairment of gas exchange, flexible bronchoscopy is contraindicated. We used the optical fiber bronchoscopy to confirm, localize, and visualize the foreign body in the distal part of tracheobronchial tree. Fiber bronchoscopy is considered as diagnostic test of choice for initial diagnosis of foreign body in adults. The advantages of this technique over rigid bronchoscopy are that it can be performed under local anesthesia, visualization of smaller peripheral airway is better with relatively easier manipulation in patients with deformations of cervical spine and pharynx (12).

Welcker et al. (2005) presented a case of failed bronchoscopy removal of the foreign body, resolved by lobectomy of right lower lobe performed because of chronic pneumonia (13). Surgical extraction of foreign body through bronchotomy or even segmental resection under general anesthesia is the last resort if extraction using bronchoscopy is unsuccessful.

Foreign bodies can remain undetected for months in adults which require a high index of suspicion for diagnosis as most adults do not recall a history of choking (14). In our case, because of her chronic obstructive disease as comorbidity, the symptoms of wheezing and choking didn't remain undetected even in this case of incomplete obstruction with foreign body. Respecting the Martinot et al. who suggested an algorithm for managing suspected foreign body aspiration that evaluates risk of foreign body based on the patient's history, presence of diminished breath sounds and findings on chest X-ray we found the aspirated foreign body very quickly (15).

Dental prosthetics such as the dental bridge aspirated by our patient represent up to twenty-seven percent of cases (16, 17). I am sure that this percentage is significantly higher because of the fact that many foreign bodies are incidentally seen on radiographic imaging ordered for symptoms mistakenly attributed to other medical conditions including chronic obstructive disease, asthma and unresolved recurrent pneumonia. Immediate removal of tracheobronchial foreign body is essential to prevent life-threatening complications. We are happy and pleased that we were able to remove the foreign body in the first 6 hours after its inhalation.

Fortunately, because of patient's epileptic seizure, after being examined by the neurologist (because of choking and coughing) she was forwarded to internal medicine ambulance. If a diagnosis of foreign body aspiration is delayed, a retained foreign body may result in unresolving pneumonia, lung abscess, and bronchiectasis. Also, formation of granulation tissue around the foreign body may occur and may resemble bronchogenic carcinoma (17, 18).

Another lucky circumstance that helped foreign body detection is the structure of denture: the denture was built of metal base under the porcelain cover.

Therefore removable partial dentures should be designed not only to preserve the remaining teeth but also to prevent accidental swallowing of these appliances. Manufacturers are advised to increase the radio opacities of these acrylic appliances to facilitate their identification after accidental swallowing or inhalation.

After the bronchoscopy intervention, in the next 5 days the patient was under bronchodilators, antibiotics and corticosteroid therapy. The control rentgenography didn't show any pathological findings. The gas analysis (pO₂ and pCO₂) and the general clinical state were normalized in the next day. Removed foreign body was given to the patient as a souvenir in remembrance of the unpleasant event: epileptic seizure with inhalation of MCB and provocation of asthmatic attack that was fully resolved.

It would be a great advantage if dentist used x-ray opaque material for dentures. Quick radiography diagnoses and quick timely appropriate intervention by bronchoscopy removal saved the patient from extensive reconstructive surgery and maybe her life.

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