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Foreign body aspiration in pandemic: Not all is Covid-19

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Description

During the COVID-19 pandemic, patients go to the emergency room of hospitals and health centers, and the first thing doctors do, is think about the SARS-CoV-2 infection, forgetting about alternative diagnoses, which leads to an over diagnosis of this infection and an under diagnosis of other pathologies, which can delay important therapeutic attitudes for patients [1].

We present the case of a patient who was misdiagnosed with SARS-CoV-2 infection.

A 49-year-old woman, non-smoker, with multiple allergies, who attended the emergency room due to a cough, chest pain in the right hemi thorax and dyspnea.

Chest x-rays and PCR tests for SARS-CoV-2 are performed, which are negative, and they are sent home, advising isolation and repeat tests.

Given the persistence of symptoms, the patient went to the Pulmonology consultation.

Physical examination: TA: 137/105, Temperature 36.6^{o}C, HR: 80/min, Sat O_2: 97%

Lung auscultation: decreased respiratory sounds in the right hemi thorax and preserved in the left.

Hemogram: 13,000 leukocytes/ mm^3 rapid SARS-CoV-2 antigen test negative.

Chest Rx PA ins / expiration: on expiration, hyper clarity is observed with an increase in volume of the right lower lobe and the middle lobe (Figure 1). Chest CT: complete occupation of the intermediate bronchus lumen by a lesion with a density of soft planes 15 mm in length (Figure 1).

Bronchoscopy: A whitish and mobile foreign body is observed at the entry of the intermediate bronchus. It is removed with a Boxton Scientific 12 mm basket and verified to be plant-based, specifically a pinion (Figure 1).

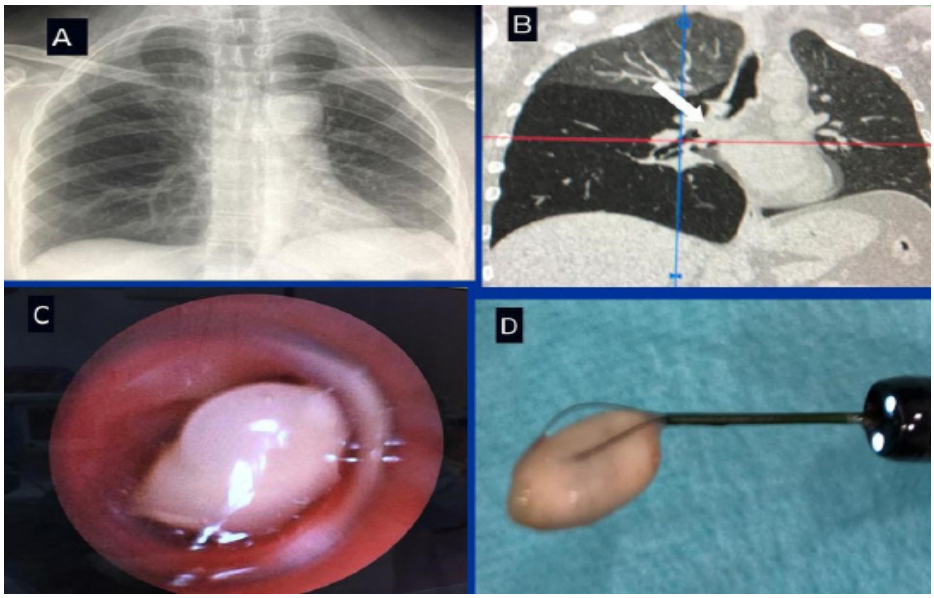

Figure 1: **(A)** Chest X-ray image with hyperinflation of the middle and lower right lobe. **(B)**: Chest CT scan with occupation of the lumen of the intermediate bronchus (arrow). **(C)**: Bronchoscopic image of the foreign body. **(D)**: Foreign body (pinion) inside the basket.

Discussion

Cough and dyspnea are two common symptoms in COVID-19 infection and in foreign body aspiration [2]. Aspiration of foreign bodies is more frequent in children and more rare in adults, the incidence increases with age and other risk factors such as alcoholism, abuse of sedatives, neurological disorders, tooth extractions, management of tracheostomies, etc., and these have been associated situations with aspirated foreign body type [3] which can be organic or inorganic.

Organics include bone fragments, fish bones, and seeds, and occur preferentially in adults. When they come into contact with the secretions of the bronchial tree, they absorb moisture and swell, and, depending on their location, they can cause an obstruction and post-obstructive pneumonia that mimics that caused by COVID-19. They can also cause an intense inflammatory reaction within the bronchial tissue, making their removal much more difficult.

Our patient had no known risk factors, and a SARS CoV-2 infection was thought; the delay in the correct diagnosis could have caused complications that fortunately did not occur.

Flexible bronchoscopy is the technique of choice for the diagnosis and removal of the foreign body. In our patient, it was performed with a 12 mm basket from Boxton Scientific; it is highly recommended that it be performed by an expert team in interventional pulmonology [4] as in the case we present.

We conclude that in the midst of this pandemic, not everything is COVID-19.

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