Evaluation for suspected Airway Foreign Body (AFB)

25 to 50% of AFBs are not witnessed and lead to a delayed diagnosis

Patient has a history or physical exam that suggests a suspected AFB

Provide appropriate emergency airway care

Is there impending/actual respiratory arrest?

Yes

Obtain chest x-ray (2 view). If patient had a CXR, of good quality and it’s reviewable, then no need to repeat.

No

Does x-ray suggest a foreign body obstruction?

Yes

Order: Chest CT indicate airway foreign body protocol

No

Continued AFB concern?

Yes

Consult ENT ASAP for consideration of a rigid bronchoscopy

No

Consider alternative diagnosis, or discharge with close follow-up

Continued AFB concern?

Yes

AFB identified?

Yes

Consider alternative diagnosis, or discharge with close follow-up

No

Consider alternative diagnosis, or discharge with close follow-up

History:
- Acute onset of choking
- Intractable cough which may diminish over time
- High suspicion of AFB per parent / caregiver
- High risk age groups (≤ 5 yoa with peak incidence between 1-2 yoa*)
- Developmentally delayed^

Physical exam:
- Stridor or focal “wheeze”
- Asymmetric breath sounds
- Decreased or absent breath sounds

*The American Association of Poison Control National Poison Data System (Gummin et al., 2018) reported that 73,503 AFB occurred, with 87% of these occurrences being in the pediatric population. In that same year, 73% of AFB ingestions were reported in children ≤ 5 yoa.

^Based on CM data (2012 - 2019) 12% of patients with a suspected AFB (N = 141) had a diagnosis associated with developmental delay.

Continued AFB concern:
- Focal findings on examination
- Abnormal chest imaging
- Acute onset of choking and intractable cough
- High suspicion of AFB per parent / caregiver
- Only 10-20% of AFB are radiopaque
- Focal air trapping may be seen acutely
- Atelectasis or post-obstructive pneumonia may be seen long term