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Abstract Only

Navigating the Airway: Anesthetic Approach to Accidental Denture Ingestion in an Elderly Patient

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ABSTRACT

Objective: Although foreign body aspiration in pediatrics occasionally encountered in anesthesia practice, accidental ingestion of dental prostheses is rare in adults and may lead to serious complications. Therefore, timely airway protection and multidisciplinary intervention are essential. This case report presents the anesthetic management of an elderly patient who inadvertently ingested a lower dental prosthesis, with an emphasis on perioperative decision-making and airway security.

Case Presentation: A 65-year-old male with a medical history of hypertension, diabetes mellitus, ischemic cerebrovascular disease, and neurogenic dysphagia was referred from the emergency department after accidental ingestion of his lower palate denture during breakfast. The patient was scheduled for urgent foreign body removal and subsequent upper gastrointestinal (GI) endoscopy. Preoperative evaluation revealed a conscious, cooperative, and oriented patient, with blood pressure 170/80 mmHg, heart rate 101 bpm, and SpO_2 90%. He had consumed solid food approximately 90 minutes prior and was unable to swallow secretions due to proximal esophageal obstruction by the prosthesis (Figure 1). To minimize secretions before induction, 0.25 mg atropine was administered and oral secretions were aspirated. Following preoxygenation with 100% FiO_2, rapid sequence induction was carried out using intravenous lidocaine (70 mg), fentanyl (75 mcg), propofol (150 mg), and rocuronium (70 mg). Videolaryngoscopy revealed the dental prosthesis lodged at the level of the larynx (Figure 2). Airway was secured with a 7.0 mm spiral endotracheal tube. The prosthesis was successfully retrieved by the ENT team (Figure 3). Subsequent upper GI endoscopy showed no esophageal injury (Figure 4). After aspirating remaining secretions, the 40-minute procedure concluded with smooth extubation using 280 mg sugammadex. The patient was transferred to the ward following stable recovery in the post-anesthesia care unit.

Conclusion: This case underscores the importance of early airway management and multidisciplinary coordination in patients with accidental prosthesis ingestion, especially those with predisposing neurological or swallowing disorders. Delayed intervention can result in catastrophic outcomes such as intestinal perforation. Videolaryngoscopy and rapid sequence induction were critical for airway safety and successful foreign body retrieval.



Figure 1. PA chest x-ray showing the ıngested dental prosthesis.



Figure 2. Videolaryngoscopic View of ıntubation and denture.



Figure 3. Dental prosthesis.



Figure 4. Upper GI endoscopy after denture removal.