CULTURAL RISK OF FOREIGN BODY ASPIRATION

**Introduction**

Wearing a head scarf is practised by certain cultures and religions including Muslim females. The head scarf may be fixed using pins, there have been previous case reports and case series of accidental inhalation of scarf pins from countries where wearing head scarves is common, such as Egypt, Kuwait and Turkey. We present a case series from a city in the UK, of females with accidental scarf pin inhalation.

**Methods**

We searched for patients who had accidental scarf pin inhalation/ingestion presenting to a tertiary care Children’s Hospital emergency department and also those that were referred to the Acute Paediatric Department at a District General Hospital from January 2008 to December 2014.

**Results**

Over a 6 year period, a total of 12 patients presented with accidental scarf pin inhalation/ingestion. The age range of these patients ranged between 11 to 14 years, with a mean of 12.3 years. All were female Muslims, with no significant past medical history. The history given was that of the scarf pin was held in the mouth, and patients reported that they sneezed, were talking at the same time, laughing or were pushed by another person as a result of which they ingested or inhaled the pin. In 9 out of 12 of these patients, the x-ray’s showed that the pin was in the stomach, and 6 of these patients had a repeat x-ray to ensure that the pin had progressed within the GI tract. In two patients the pin was inhaled and was found to be in the left main bronchus and in one patient the pin was found to be in the upper airway on chest x-ray. All three patients required laryngotracheobronchoscopy and foreign body removal.

**Conclusion**

Health professionals working in a multi-cultural area need to be aware of this presentation and appropriate management. Wider educational measures are required in order to increase awareness regarding avoidance of placing the scarf pins in the mouth whilst placing head scarves.

### Abstract G85(P) Table 1

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No F/U</th>
<th>GP F/U</th>
<th>Daycase</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEM</td>
<td>2 (62%)</td>
<td>5 (50%)</td>
<td>3 (9%)</td>
<td>0</td>
</tr>
<tr>
<td>PN</td>
<td>5 (50%)</td>
<td>5 (50%)</td>
<td>0</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>PG</td>
<td>15 (52%)</td>
<td>14 (48%)</td>
<td>1 (3%)</td>
<td>3 (16%)</td>
</tr>
</tbody>
</table>

**Conclusions**

An incidental finding of haematuria/proteinuria is common in CED. Approximately 2/3 of microscopic haematuria/proteinuria in children without specific renal symptoms resolves. Ensuring resolution is important since up to 50% of children in whom it persists have renal disease.1 Here we show a trend for nephrologists to follow up more urine dipstick results but for PEM doctors to admit more children for inpatient investigations. PEM doctors and general paediatricians tend to have similar patterns of follow up.

**REFERENCE**