



**Figure 10-5**

(A) Lateral abdominal survey radiograph of a cat with hair ball foreign body. A soft-tissue density is noted extending cranially and caudally from the thoracic inlet. Ventral depression of the trachea by the soft-tissue density is also noted. (B) On endoscopic evaluation the proximal aspect of the hairball was found just inside the upper esophageal sphincter. Fragmentation of the hairball necessitated multiple extractions (C). For this reason, a rigid endoscope was passed in place of a flexible endoscope. This allowed the rigid endoscope to remain in place while multiple fragments were removed with an alligator-type forceps.



**Figure 10-6**  
Demonstration of the proper positioning of a foreign body against the end of the endoscope for removal.

be managed conservatively with intravenous fluids, broad-spectrum antibiotics, and gastrostomy tube feedings. Large perforations require surgical intervention.

## Gastric Foreign Bodies

Gastric foreign bodies are much more commonly encountered in dogs and cats than esophageal foreign bodies. Commonly ingested foreign bodies in dogs include bones, rocks, clothing, plastic and rubber toys, apricot or peach pits, fishhooks, and coins.<sup>9,11</sup> In cats, sewing needles and trichobezoars are commonly encountered.<sup>9,11</sup> Endoscopy is useful to confirm a suspected gastric foreign body, and more importantly, to remove these objects.

The most common clinical sign associated with gastric foreign bodies is vomiting. If the object is small and freely movable, only intermittent vomiting may be observed. Inappetence, lethargy, and mild abdominal tenderness may also be noted. Pain and fever in combination suggest perforation. As opposed to esophageal foreign bodies, removal of gastric foreign bodies is less commonly considered an emergency procedure. Large, sharp, or linear objects should be removed promptly to avoid GI perforation or obstruction. Although sharp objects such as sewing needles have the capability of passing through the GI tract without incident, these objects also have the capability of perforating the intestinal wall and causing peritonitis. Thread attached to a ingested sewing needle, if of significant length, also could lead to intestinal plication if the needle were to become impacted or impaled at the pylorus with the thread moving progressively down the small intestine. Objects suspected of containing lead, zinc (*e.g.*, pennies minted after 1982), or caustic materials (*e.g.*, batteries) must be removed immediately. Clinical signs in these cases may be related to the inherent toxicity of these metals (*e.g.*, seizures for lead, hemolytic anemia for zinc) or chemicals. Foreign bodies that cause acute, severe vomiting (most notably objects lodged in the pylorus) can result in life-threatening metabolic disturbances and should be removed immediately. Objects lodged in the pylorus also are often associated with marked abdominal pain. If in doubt whether an object should be removed, remove the object. Endoscopic removal from the stomach is less invasive and has less potential for complications than surgical removal from the stomach or intestine. Prior to inducing general anesthesia, fluid and electrolyte abnormalities should be corrected. In addition, radiographs may need to be repeated if a sig-