

## Transient tracheo-bronchial aspiration of capsule endoscope

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An 81 year-old man with personal history of Alzheimer's disease and under antiplatelet drugs therapy presented with melena and no other symptoms. No source of bleeding was obtained at conventional upper and lower gastrointestinal endoscopy. Thus, video capsule endoscopy was indicated. Although the patient had not history of swallowing disorders and/or dysphagia, the ingestion of the capsule endoscope precipitated self-limited coughing. When capsule endoscope was reviewed the device was located at the tracheo-bronchial system (B-C) for 17 seconds. No symptoms were observed during this period. Afterwards, capsule endoscopy migrated spontaneously to the oro-pharyngeal cavity (A-D) and continued across the gastrointestinal tract until cecum was reached. Patient remained asymptomatic and no bronchoscopic extraction was demanded. Capsule endoscopy is currently considered as a first line diagnostic tool for small bowel examination. It has been demonstrated to be an accurate, painless and well-tolerated procedure. However, although it is a very safe technique, few adverse events have been published. Tracheo-bronchial aspiration is an uncommon but dangerous capsule endoscopy-related adverse event, as the device can be retained in the airway, resulting in potential respiratory failure (1). It usually migrates spontaneously, although bronchoscopic extraction in some cases may be needed (2). The incidence of capsule aspiration is very low (< 0,003%) (3), being frequently in patients with dysphagia and/or swallowing disorders. Therefore, capsule endoscope should be endoscopically placed in the duodenum in those patients at risk of capsule retention to prevent tracheo-bronchial aspiration.

### References

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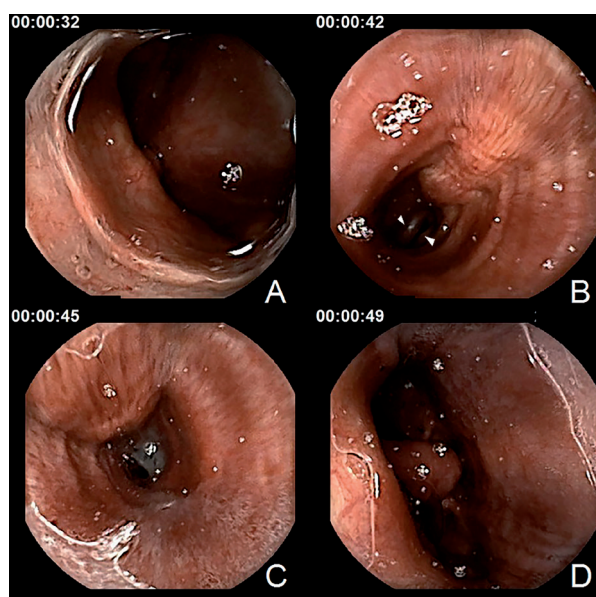


Figure 1. — Oro-pharyngeal cavity before (A) and after (D) asymptomatic capsule aspiration. Vocal cords detected by capsule endoscope (B, head arrows) when the device was located inside the tracheo-bronchial system (C).

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