**Foreign Body in the Tonsil**

September 08, 2010 | [Pediatric Skin Diseases](http://www.pediatricsconsultantlive.com/pediatric-skin-diseases) [1], [ADHD](http://www.pediatricsconsultantlive.com/adhd) [2]
By [Capt Kevin W. Johnson, MD](http://www.pediatricsconsultantlive.com/authors/capt-kevin-w-johnson-md) [3]

The mother of an 8-year-old boy sought medical care for her son, who had complained of a sore throat for 3 days. No fever, drooling, rash, rhinorrhea, cough, congestion, ear pain, neck stiffness, or dyspnea was reported. The boy had not been in contact with any ill persons, although his complaints coincided with a local outbreak of streptococcal pharyngitis.

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The patient appeared to be well nourished and in no distress. His head was normocephalic. His neck was supple and showed no masses or lesions. Review of systems was otherwise unremarkable. The patient’s mucous membranes were moist; dentition was normal; his tonsils were of a normal size at 2+; and his oropharynx was pristine, in general, except for an area on the anterior left tonsil.

Capt Kevin W. Johnson, MD, USAF MC, of Langley Air Force Base, Va, noted a dark-colored, fibrous, 1-cm protrusion. A small ring of white adherent exudate, which was surrounded by another small ring of erythema, was noted at the base of the lesion. Little swelling could be appreciated. There was no active bleeding, evidence of blood, or drainage. Gentle manipulation and palpation of the lesion was only slightly uncomfortable and produced no drainage or bleeding. The protrusion was hard, yet slightly flexible. It was not friable.

On further questioning, the child admitted he had fallen into a large bush 3 days before presentation while playing football. When running to catch a pass, he noted the fast-approaching bush. Rather than stopping, he released a primal scream as he dove into it to demonstrate to the other players his eagerness to participate, selfless courage, and passion for the game. Unfortunately, he dropped the pass. Interestingly, he had no visible skin abrasions from his collision with the bush.

A phone call from Dr Johnson to an otolaryngologist led to a consultation later that same day. The ENT noted the presence of a 16-mm twig embedded in the child’s tonsil. He was able to remove all of it under topical anesthesia. The child tolerated the removal well. The resulting small surgical wound was irrigated copiously with sterile saline. A 10-day course of amoxicillin/clavulanate was prescribed. At follow-up, he was doing well.

The case illustrates an uncommon and interesting cause of a frequent complaint. As usual, the history is paramount, although sometimes not easy to extract.

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