Known or Suspected Button Battery Ingestion

Active Bleeding or Sentinel Bleed?

Yes

Trauma Red Activation

Obtain chest x-ray to assess for battery location if patient is stable without active bleeding. If patient is actively bleeding, proceed to Hybrid Cardiac Catheter lab and use fluoroscopy (c-arm) to assess for battery location.

Hybrid operating room

Massive transfusion protocol for actively bleeding patient

Blakemore tube to bedside

Consults to cardiovascular surgery, gastroenterology, and interventional cardiology

No

Emergent Chest X-ray

In esophagus?

Yes

Emergent endoscopic removal in OR

Is battery greater than 20mm? And child less than 5 y.o.?

Yes

Consider endoscopy to assess esophagus and remove battery

Observation

Follow-up with x-ray:
- In 48 hours for batteries greater than or equal to 20mm
- In 10-14 days for batteries less than 20mm

Endoscopic removal if battery still in stomach at repeat x-ray

No

Observation

Follow-up with x-ray:
- In 48 hours for batteries greater than or equal to 20mm
- In 10-14 days for batteries less than 20mm

Endoscopic removal if battery still in stomach at repeat x-ray

Inclusion Criteria:
Any patient with suspected or known ingestion of a button battery

Exclusion Criteria:
Patients with ingestion of foreign bodies other than button batteries
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TARGET POPULATION

Inclusion Criteria
- Any patient with suspected or known ingestion of a button battery

Exclusion Criteria
- Patients with ingestion of foreign bodies other than button batteries

INTRODUCTION

Button battery ingestions are potentially life-threatening for children. Catastrophic and fatal injuries can occur when the battery becomes lodged in the esophagus, where battery induced injury can extend beyond the esophagus to the trachea or aorta. Increased production of larger, more powerful button batteries has coincided with more frequent reporting of fatal hemorrhage secondary to esophageal battery impaction.

ETIOLOGY

The mechanism of injury of esophageal battery impaction is electrochemical. Esophageal tissue simultaneously contacts the positive and negative electrodes, which lie in proximity. The flow of electricity then leads to pH changes in surrounding tissue. Experimental models have clearly demonstrated more severe injury in esophageal
tissue approximating the negative pole of the battery, where pH changes are alkaline. The orientation of the battery within the esophagus may be helpful in predicting the anatomic direction of tissue necrosis and thus the extra-esophageal structures at highest risk of injury.

There is very rapid onset of tissue injury and injury continues for days to weeks after removal of the battery. The most common cause of death from button battery ingestion is due to the formation of an aortoesophageal fistula (AEF).

INITIAL TRIAGE AND ASSESSMENT¹⁻³

Telephone Triage

- Advise parent or caregiver to seek immediate emergency medical care

**Note:** Esophageal batteries should be removed within two hours to minimize injury to tissues

- Advise parent *not* to induce vomiting

**Note:** Induced vomiting rarely expels the battery

- Advise parent not to give the child anything by mouth

**Note:** Anesthesia may be required for removal of battery, nil per os (NPO) status should be maintained until esophageal position is ruled out by radiograph

Clinical Assessment

History and Physical Examination

Consider battery ingestion if:

- Airway obstruction or wheezing
- Drooling
- Vomiting
- Chest discomfort
- Difficulty swallowing, decreased appetite, refusal to eat
- Coughing, choking, or gagging with eating or drinking

Radiological Assessment

- In *all* patients with a witnessed or suspected button battery ingestion:
- Obtain urgent radiograph (X-ray) of abdomen, esophagus, and neck to locate the battery

TREATMENT¹⁻³

Ineffective interventions that should be *avoided* include:

- Ipecac administration
- Chelation therapy
- Laxatives or polyethylene glycol electrolyte solution
- Blind battery removal with a balloon catheter or a magnet affixed to a nasogastric tube

MANAGEMENT OF ESOPHAGEAL BUTTON BATTERY IMPACTION

Animal data demonstrates esophageal mucosal injury within minutes of button battery contact. Case reports demonstrate that lethal injury can be sustained in a matter of a few hours. If battery is located in the esophagus
immediate removal is essential. Arrange emergent transport to center with pediatric endoscopic capability if unavailable at current location.

- Alert procedural service as soon as Emergency Department (ED) is aware of patient, even if still at outside facility.
- Procedural service to contact Anesthesia, to arrange emergent operating room (OR) time for removal. Blakemore tube should be available in OR at time of battery removal.
- Pediatric surgery should be alerted prior to removal of all esophageal button batteries because rigid esophagoscopy may be necessary.

**MANAGEMENT OF GASTRIC OR INTESTINAL BUTTON BATTERY IN ASYMPTOMATIC CHILD**

The most typical ingestion scenario involves witnessed battery ingestion and the rapid transit of the battery to the stomach. Based on recommendations from the National Battery Ingestion Hotline, these children are not at risk of severe injury and can be observed. Larger button batteries (larger than 20 mm) in younger children (less than 5 years of age) are less likely to traverse the pylorus.

- If ingestion was witnessed and passage was prompt to the stomach, in the asymptomatic child observation is appropriate if the child is (≥) 5 years and older AND/OR the button battery is less than or equal to (≤) 20mm diameter.
  - When outpatient observation is appropriate for intragastric batteries, a repeat x-ray is recommended in 48 hours for batteries greater than or equal to (≥)20mm in diameter and in 10-14 days for batteries less than (<)20mm diameter. If battery has not traversed pylorus at time of repeat x-ray, or if patient develops gastrointestinal symptoms such as pain, nausea, vomiting, or anorexia, endoscopic removal is recommended.
- In the following scenarios upper intestinal endoscopy should be considered in assessment for esophageal injury and endoscopic battery removal, where possible: 1) unwitnessed ingestion and therefore unknown duration of battery in the gastrointestinal tract, 2) child less than (<) 5 years old and battery greater than (>)=20mm in diameter.

**MANAGEMENT OF GASTRIC BUTTON BATTERY IN SYMPTOMATIC CHILD**

Gastric injury from button batteries has been rarely reported. However, the child may have sustained significant injury to the esophagus during passage of button battery. Pain or vomiting should lead to prompt endoscopic evaluation to assess for esophageal injury. Urgent endoscopic assessment of esophagus is required in the Operating Room with removal of battery from stomach.

- Blakemore tube should be available at time of removal.

**MANAGEMENT OF UNSTABLE, ACTIVELY HEMORRHAGING CHILD WITH SUSPECTED VASCULAR INJURY**

This is a life-threatening emergency requiring immediate intervention. Endoscopic intervention is of marginal to no benefit in controlling hemorrhage from an AEF. Radiologic procedures may delay necessary surgical intervention. Blakemore tube may provide temporary control of bleeding but definitive surgical intervention is necessary.

- Trauma Red Activation.
- Placement of two large-bore IV catheters
- Blakemore tube to bedside (12 French – pediatric size) with manometer (mmHg)
- Emergent consultation to gastroenterology, pediatric surgery, pediatric cardiothoracic surgery, interventional cardiology.
• Immediate transport to Hybrid Cardiac Catheter Lab (3rd floor, adjacent to cardiac surgery operating rooms) for definitive intervention.

MANAGEMENT OF **STABLE CHILD WITH HISTORY OF SENTINEL BLEED (HEMATEMESIS OR MELENA) AND KNOWN OR SUSPECTED BUTTON BATTERY INGESTION**

Development of aortoesophageal fistula may occur in the presence of the battery or post-removal in the setting of sustained severe esophageal injury. A sentinel bleed may precede (by hours) a more severe, exsanguinating hemorrhage event. A high index of suspicion should be maintained for aortoesophageal fistula.

**Multi-disciplinary intervention is necessary, diagnostic testing should be immediate, and high-volume bleeding should be anticipated.**

- Trauma Red Activation.
- Placement of two large-bore IV catheters
- Type and cross patient for possible blood transfusion
- Blakemore tube to bedside (12 French – pediatric size) with manometer (mmHg), to follow patient to OR.
- Immediate transport to Hybrid Cardiac Catheter Lab.
- If not previously performed, obtain portable x-ray to confirm button battery location.
- Emergent consultation to gastroenterology, pediatric surgery, pediatric cardiothoracic surgery, interventional cardiology. If button battery is present in esophagus, proceed with emergent removal. Both cardiothoracic and pediatric surgery teams should be present in the OR. The patient should be prepped for thoracotomy. Endoscopic battery removal in a patient with aortoesophageal fistula may precipitate life-threatening hemorrhage and must be approached with caution. For high suspicion of aortoesophageal fistula (AEF), initial surgical approach should be thoracotomy with control of major vessel injury.
- If button battery is not present in the esophagus, consider computed tomography (CT) angiogram to evaluate for aortoesophageal fistula
- If AEF confirmed by CT angiogram, proceed with emergent open surgical intervention. Anticipate combined Cardiothoracic and Pediatric Surgery approach.
- If AEF not visualized by CT angiogram, proceed to upper endoscopy for evaluation of bleeding source. Endoscopic evaluation should take place in the Hybrid Cardiac Catheter Lab. Pediatric surgery and CT surgery should be present at time of endoscopy with surgeons and OR staff prepared for emergent thoracotomy.

**Protocol for Blakemore Tube Insertion for Actively Bleeding Patient with suspected esophageal source:**

- Rapid sequence intubation followed by oral placement of Blakemore tube. Place 50 mL of air in gastric balloon, confirm gastric placement radiographically or clinically. Clamp gastric balloon intake lumen. Pull back on tube until gastric balloon seated at gastroesophageal junction.
  - Inflate esophageal balloon to 30 to 40mmHg. Rate of ongoing bleeding can be assessed by aspirating gastric contents from Blakemore. If necessary, increase pressure incrementally until bleeding slows.
  - Clamp esophageal balloon intake lumen.
  - Place suction tube in esophagus alongside Blakemore tube to rest above esophageal balloon, connect to continuous suction
  - Blakemore tube should not be used when a battery is present in the esophagus.
SURVEILLANCE AFTER BUTTON BATTERY REMOVAL

Post-removal complications include the development of fistula into a major vessel, such as aortoesophageal fistula, which has been described up to 18 days after battery removal. Other complications include development of mediastinitis, tracheoesophageal fistula, and esophageal stenosis. There are no published data regarding the efficacy of post-removal surveillance. Degree of endoscopic ulceration may belie the extent of para-esophageal injury. Expectant management of patients is to include anticipatory guidance regarding concerning symptoms: vomiting blood (bright red or specks of black/dark red), melena, cough, fever.

More active surveillance may allow for earlier diagnosis of complications and an opportunity for intervention prior to catastrophe.

- For children with no or minimal esophageal mucosal injury visible on endoscopy, child may be successfully discharged same-day with expectant management by primary care provider.
- For moderate or severe esophageal mucosal injury, consider placement of a soft feeding tube at time of endoscopy. Obtain a contrast esophagram immediately after endoscopy to look for extravasation of contrast into the extra-esophageal space. If esophagram demonstrates perforation, treat with IV antibiotics, maintain NPO or provide nutrition via feeding tube
  - Admit patients for monitoring.
  - Multi-disciplinary approach including pediatric surgery, pediatric gastroenterology, pediatric otolaryngology, and pediatric radiology is advised.
  - MRI protocols have been developed at CHCO for surveillance imaging post-battery removal. Although no formal guidelines have been established for timing of imaging post-removal following moderate/severe injury, MRI has been obtained typically 3-5 days after removal. However, the timing of imaging would depend also on how long the battery had been impacted in the esophagus prior to removal.

PATIENT | CAREGIVER EDUCATION

Upon discharge from the hospital, anticipatory guidance should be given to families regarding the range of potential complications of esophageal button battery impaction, which include vascular injury with hemorrhage, tracheo-esophageal fistula, mediastinitis, vocal cord injury, esophageal stenosis, and spondylodiscitis.

DISCHARGE CRITERIA

Prior to hospital discharge, in all patients with moderate-severe esophageal injury, we suggest endoscopic or radiologic surveillance studies to look for evidence of poor healing or evidence of extra-esophageal injury. Because catastrophic hemorrhage has been seen up to 3 weeks after battery removal, consideration of the timing of hospital discharge must include the proximity of the family to a pediatric facility capable of managing life-threatening bleeding.
REFERENCES


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