



Oesophageal Foreign Bodies in Dogs and Cats

Quick Take

An oesophageal foreign body (EFB) occurs when food, bone, toys, needles, fishhooks, rawhide, or other objects become stuck in the oesophagus, the muscular tube connecting the throat to the stomach.

This is an emergency because:

- The object can block swallowing
- Pressure can damage the oesophageal lining
- The wall may tear or perforate
- Severe inflammation can cause stricture (scar-narrowing)

Some objects (e.g., bones, fishhooks) can cause rapid tissue damage

Treatment almost always requires **endoscopy or surgery**.

Early removal dramatically improves outcomes.

1) What's going on inside?

The oesophagus is a delicate tube whose job is to **move food to the stomach**. It is not meant to hold objects. When something gets stuck:

Stage 1: Obstruction

Food and saliva build up behind the blockage

The pet drools, swallows hard, or vomits

Stage 2: Pressure injury

Within minutes to hours, the object compresses the oesophageal wall, leading to:

- Pain
- Tissue swelling
- Reduced blood flow

Stage 3: Tissue damage

The longer the object remains:

- The lining ulcerates
- The wall weakens
- Necrosis (cell death) begins

Stage 4: Complications

If untreated, EFBs can cause:

- Oesophageal perforation (life-threatening)
- Mediastinitis (infection of chest cavity)
- Aspiration pneumonia
- Stricture formation (can severely affect eating)

2) Common causes / types of foreign bodies

In dogs:

- Bones (especially rib bones)
- Rawhide
- Toys or toy fragments
- Balls
- Needles or sewing items



- Fishhooks
- Dental chews
- Large treats

In cats:

- Fishhooks
- Needles + thread
- String
- Bones from human food
- Toys

Locations where EFBs most often lodge:

- Thoracic inlet (base of neck)
- Heart base area
- Hiatal region (near diaphragm)

These are **natural narrowings of the oesophagus**.

3) What owners typically notice

Classic signs:

- Gagging or retching
- Hard swallowing or repeated gulping
- Drooling
- Vomiting or regurgitating foam
- Pacing, distress
- Pain when touching neck or chest
- Refusing food
- Regurgitating water after drinking
- Pawing at the mouth
- Sudden anorexia

Severe signs:

- Collapse
- Trouble breathing
- High fever
- Weakness
- Signs of shock
- Regurgitation with blood

If a foreign body is suspected, immediate veterinary care is essential.

4) Diagnosis

A) Physical exam

Pain in neck or chest
Drooling
Dehydration
Possible fever
Dilation of the cervical segment of oesophagus.

B) X-rays

Many objects are visible
Contrast studies sometimes needed
Shows air buildup, fluid, or oesophageal dilation
Can show more advanced stages of mediastinitis.

C) CT scan

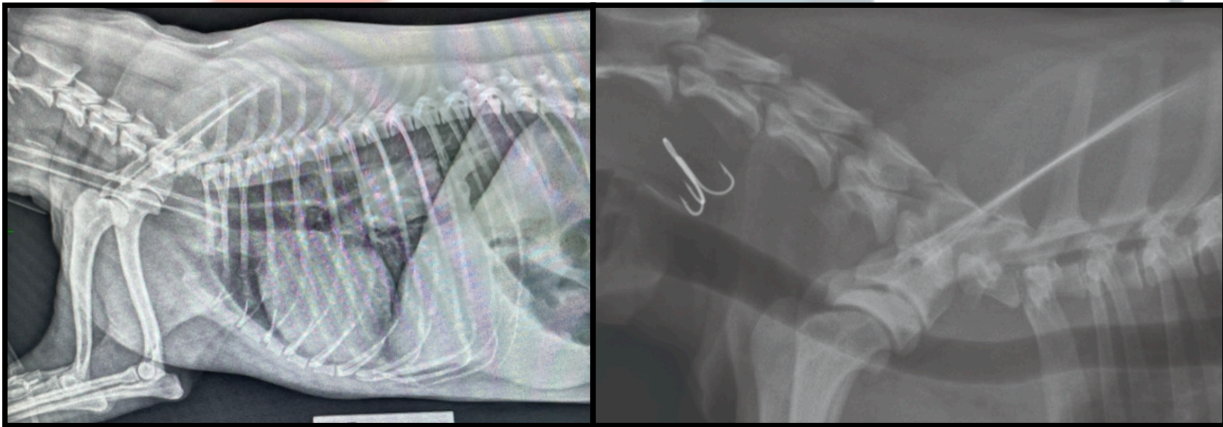
Useful in complicated or sharp-object cases.

Can help as well in cases with long-standing foreign body

D) Endoscopy

Best diagnostic and treatment tool.

Allows direct visualisation and removal of the foreign object.



5) Treatment options

There are three main approaches:

A) Endoscopic removal → Gold standard

B) Push into stomach + remove surgically

C) Open oesophageal surgery (less frequent, requires more experience and more risk)

6) Endoscopic Removal

First-choice treatment for almost all oesophageal foreign bodies
Performed with a flexible camera under general anaesthesia.

Procedure:

The endoscope is passed into the oesophagus
Graspers, baskets, or snares latch onto the object
Object is removed safely through the mouth
The oesophagus is inspected for damage

Advantages:

Minimally invasive
Very **high success rate** (80–95%) with the adequate equipment
Fewer complications
No external incision
Oesophagus typically heals quickly
A temporary feeding tube is often needed to allow adequate healing of the oesophagus.

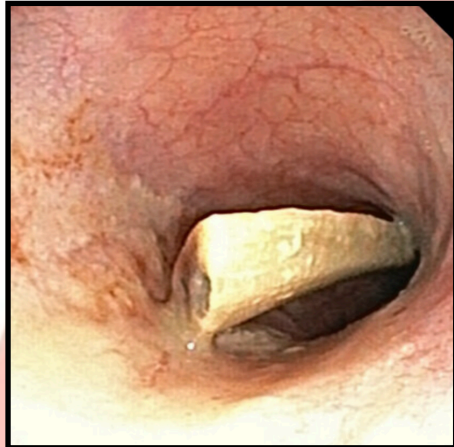
Limitations:

Not suitable when the oesophagus is perforated- Perforation is rarely predictable
Not effective if the object is deeply embedded



Some objects cannot be retrieved safely (e.g., curved fishhooks)

!!! Any person attempting removal of the foreign body should be prepared and experienced enough to handle an emergency thoracic surgery if there is any sudden pneumomediastinum at the time of the foreign body retrieval. Sudden decompensation can occur when a foreign body has already ruptured the oesophageal wall and is retrieved via scope!!!



Endoscopic view of a lamb rib in the caudal third of the oesophagus

7) Pushing the object into the stomach

When removal upward is **dangerous or impossible**

This is a common alternative if:

- The **object is too large**
- It is **stuck firmly**
- It is safer to move it than pull it backward

Once pushed into the stomach, the object can be removed via a **gastrotomy** (surgical opening into the stomach). This is significantly safer than oesophageal surgery. The stomach heals very well and there is less anticipated morbidity than with a chest surgery. Lower risk of complications than cutting into the oesophagus.

8) Open Oesophageal Surgery (Oesophagotomy/oesophagectomy)

Because the oesophagus does not heal as well as other organs, **open surgery is avoided unless:**

- The object is sharp and cannot be safely removed endoscopically
- The oesophagus is perforated
- A fishhook is embedded
- The object has migrated into surrounding tissues
- Massive necrosis or abscess formation is present
- Any large foreign body that would have spent more than 3-4 days in the oesophagus.

Risks of oesophageal surgery:

Leakage (serious, life-threatening)
Infection
Scar formation (stricture)
Poor wound healing

Success rates:

Highly variable. Require both expertise and some equipment (ventilator) that a Specialist can provide. Higher complication rate than endoscopy or gastrotomy.



Requires specialist surgeon

9) Complications and realistic rates

Complication	Rate	Notes
Esophagitis (inflammation)	Common	Usually mild to moderate
Stricture (scar narrowing)	10–25%	Higher with prolonged obstruction
Perforation	5–15%	Life-threatening
Aspiration pneumonia	10–20%	Requires aggressive treatment
Esophageal leak after surgery	<10–15%	Major complication
Death perioperatively	5–15%	Depends on severity and delay

Most complications are **related to delayed treatment or poor surgical technique**, not the procedure itself.

10) Aftercare and recovery

After endoscopic removal:

- Soft diet for 5–14 days
- Pain management
- Anti-inflammatories / sucralfate to coat the esophagus
- Treat esophagitis (common and expected)
- Possible antacids (omeprazole)
- No toys or bones until healed

After surgical gastrotomy:

- 10–14 days of rest
- Soft diet
- Pain relievers
- Monitor incision
- Usually excellent recovery

After open oesophageal surgery:

- Strict rest 2–4 weeks
- Feeding tube (often required)
- Intensive monitoring for the initial 24–48h of recovery.
- Follow-up imaging to detect early signs of mediastinitis
- Higher risk, longer recovery. Can require four days in hospitalisation.

11) Long-term outcome

With prompt endoscopic removal:

- Excellent prognosis
- Most dogs and cats recover fully
- Esophagitis resolves
- Strictures rare with early treatment



- Return to normal eating within days

With delayed treatment:

Higher risk of stricture
Increased chance of oesophageal perforation
Possible need for multiple balloon dilations
Longer recovery
Increased mortality

Early diagnosis and removal make the biggest difference in outcome.

12) Preventing recurrence

- Avoid giving dogs bones, rawhide, or toys that can be swallowed whole
- Choose chew toys sized for your dog's breed
- Keep sewing items, fishhooks, strings, and needles away from cats
- Feed cats appropriate chewable treat sizes
- Supervise pets with new toys

Avoid cooked bones entirely — never safe

13) Selected Veterinary References

- ACVS — Oesophageal Foreign Bodies
- VCA — Foreign Objects in oesophagus of Pets
- Stokol et al., J Vet Intern Med — oesophageal foreign body outcomes
- Norris CR, Vet Clin North Am Small Anim Pract — oesophageal disorders in dogs and cats
- Leib & Willard, Textbook of GI Endoscopy in Small Animals
- Fossum TW — Small Animal Surgery, chapter on oesophagus

Bottom Line

Oesophageal foreign bodies are an **emergency requiring immediate veterinary care.**

Endoscopy is the treatment of choice in most cases, offering excellent outcomes with minimal invasiveness.

When endoscopy is not possible, pushing the object into the stomach and removing it surgically is safer than cutting into the oesophagus.

Oesophageal surgery is a last resort, reserved for perforations, fishhooks, or severe cases where other methods fail and should involve a specialist.

Early removal = fewer complications and a much better prognosis.

If endoscopy is attempted, you should already have a surgical backup