**Keywords:** foreign body, laryngeal stenosis, child, laryngoscopy

The wide prevalence of cases of foreign bodies in the larynx in children is caused both by anatomic and physiological peculiarities, and immaturity of the child’s protective mechanisms, especially in premature babies, whose protective reflexes are reduced. Foreign bodies of the upper respiratory tract remain a major cause of both morbidity and mortality in early childhood, especially in the cases of the emergency aid providing delays. Meanwhile, the history data are not always specific for aspiration, and the clinical picture is sometimes far from straightforward, and may resemble other common diseases of childhood, such as, for example, in the following clinical case.

A child K., 10 months aged, entered the infants’ infectious department of Zaporozhye City Multidiscipline Pediatric Hospital №5 with a diagnosis of viral acute stenosing laryngotracheitis (croup), stenosis of the larynx of the 1st degree.

The illness has developed acutely, a few hours before admission voice hoarseness and shortness of breath appeared. Objectively in admission there were an anxiety of the child, while weeping - noisy breathing difficulties, supporting muscle participation in the act of breathing, voice hoarseness. During more than a day and a half the child received an appropriate treatment including inhalations, parenteral corticosteroids at a dose of 6-8 mg / kg / day, and antibiotic therapy. The child's condition has worsened, and 44 hours after admission the child moved to the Intensive Care Unit (PICU). B PICU the treatment was continued by, increased dose of corticosteroids to 10 mg / kg / day. However convincing clinical effect in 12 hours has not been received, and therefore it was decided to carry out endotracheal intubation to ensure the upper respiratory tract prosthetics. A direct laryngoscopy was carried out: the expressed subglottic edema was defined, almost completely blocking the lumen of the airways.

An experienced anesthesiologist managed to carry out orotracheal intubation with a great difficulty. Endotracheal tube with an internal diameter of 2.5 mm was used, all attempts to introduce larger tube to the larynx failed. Due to the dubious effectiveness of the ventilation through such a narrow tube, tracheostomy was made urgently; tracheostomic tube with an internal diameter of 4 mm was inserted. During the first day, an assisted mechanical ventilation was carried out, and then the child was on spontaneous breathing, getting humidified oxygen therapy.

From the second day of a child’s stay in the PICU inflammatory changes in the clinical analysis of a blood attracted attention: leukocytosis, the appearance of young forms of neutrophils (up to metamyelocytes), acceleration of ESR. In addition to respiratory therapy, the child receives antibacterial and antifungal agents, anticoagulants, broncholytics and mucolytics. Besides, regular sanitation of the upper respiratory tract and the tracheobronchial tree, and the correction of electrolyte disturbances were conducted. Radiological research revealed atelectasis of right lung upper lobe, which resolved within a week.

After stabilizing the patient's condition, we decided to conduct a diagnostic bronchoscopy using a fibreoptic bronchoscope "Pentax" with a 5 mm diameter of working part. The laryngoscopic examination revealed that the glottis above the vocal cords was on 2/3 covered with whitish formation located mainly on the right vocal cords, pushing it laterally. An attempt to remove this formation with the help of aspiration failed. The formation was removed with a third attempt using biopsy forceps. There were no signs of bleeding from the tissues of the larynx there. At examination of macropreparations identified a fragment of bone that looked like a chicken leg bone, diamond-shaped, measuring about 0.6 to 0.9 mm.

In this case, the clinic of growing upper airway stenosis initially accepted as the manifestation of stenotic laryngotracheitis of the viral etiology ("false croup") was caused by the atypical location of the laryngeal foreign body presumably aspirated when eating. Thus, the clinical picture of a foreign body aspiration is diverse and non-specific, and sometimes far from being a classic one. Taking into consideration the ability of this disease to "disguise" a suspicion of the foreign body aspiration should probably appear in all cases, when there is the lack of standard therapy effect of some diseases of the upper or lower respiratory tract.