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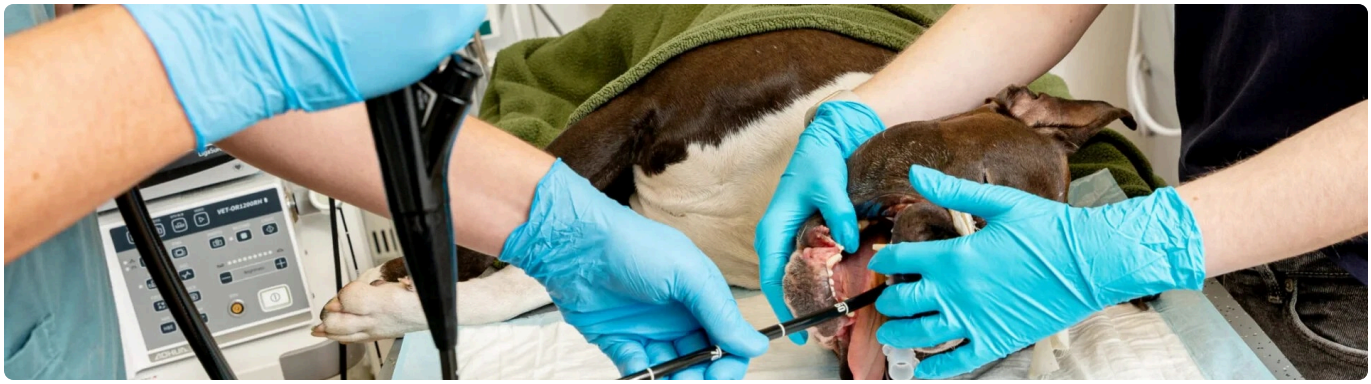
EMERGENCY & CRITICAL CARE SERIES · CLINICAL RESOURCE 2 OF 3

Gastrointestinal Foreign Bodies

Endoscopic Retrieval & Equipment Selection Guide

For: veterinarians, RVTs, veterinary nurses & technicians **Setting:** Canadian small-animal practice **Edition:** November 2026

An impacted oesophageal bone, a smooth object in the stomach and a linear foreign body extending into the intestine are three different clinical problems. Whether endoscopy is appropriate depends on location, shape, duration, tissue viability, patient stability and the team's expertise, not simply on whether an endoscope is available. This guide sets out those considerations, and the equipment specifications that actually matter for retrieval.



Flexible endoscopy in a dog under general anaesthesia. Photo © DAC Maas en Niers. Used with permission. Source: dacmaasenniers.com

1 Oesophageal, gastric and intestinal foreign bodies compared

	Oesophageal	Gastric	Intestinal
Typical presentation	Regurgitation, dysphagia, hypersalivation, repeated swallowing. Owners may describe this as "vomiting".	Vomiting, which is usually active, with retching and abdominal effort.	Vomiting and signs of obstruction; linear material may cause plication.
Where objects lodge	Often at anatomical narrowings: thoracic inlet, heart base, caudal oesophageal sphincter.	Within the gastric lumen.	Small intestine; a linear object may anchor proximally (for example, the pylorus or base of the tongue).
Key tissue risk	Pressure injury: inflammation, ulceration, necrosis and, in severe cases, perforation.	Mucosal injury, particularly with sharp objects.	Pressure injury, ischaemia and perforation; compromised bowel.
Endoscopy may be relevant when	The object is reachable in the lumen and can be moved without excessive force.	The object is accessible and graspable.	Rarely as a stand-alone approach. Surgical assessment is commonly required.

Presentations overlap; an owner's timeline may be incomplete, and a bright patient does not guarantee healthy mucosa.

2 Assessment, imaging and stabilization priorities

Before any retrieval

- Assess and stabilize the patient first. Retrieval requires general anaesthesia and airway protection.
- Establish the history: object type, possible timing of ingestion, and whether signs are regurgitation or vomiting.
- Consider complications already present, such as aspiration or suspected perforation.
- Agree in advance what happens if the object cannot be moved safely: surgery, referral, or both.

What imaging can and cannot answer

- Cervical and thoracic radiographs localize radiopaque oesophageal objects and may reveal complications.
- Radiolucent material is harder to identify. Abdominal radiography and ultrasound help assess gastric or intestinal obstruction, associated changes and free peritoneal fluid.
- Imaging rarely shows how adherent an object is, or whether it can be grasped. Intriquip's **veterinary imaging equipment** supports diagnosis; it does not establish endoscopic suitability.

3 Evaluating endoscopic retrieval versus surgery

Endoscopy can allow retrieval of selected oesophageal and gastric foreign bodies without an abdominal incision, while permitting direct examination of reachable mucosa. That is not the same as endoscopy always being safer than surgery.

Factor	Supports considering endoscopy	Raises concern / favours surgical assessment
Location	Oesophageal or gastric; reachable through the lumen.	Small-intestinal involvement; material beyond reach.
Object	A shape that can be grasped and withdrawn with acceptable risk.	Smooth objects difficult to grip; sharp objects hazardous to withdraw; linear material.
Tissue	Mucosa viable on inspection; no evidence of perforation.	Suspected full-thickness injury or perforation; friable, inflamed tissue around an impacted object; questionable bowel viability.
Resources	Suitable scope, compatible retrieval instruments, trained operator, anaesthesia support.	Required scope or instrument unavailable; no means of converting to another approach.

⚠ IMPACTED OESOPHAGEAL OBJECTS

A bone lodged in the oesophagus may be surrounded by inflamed, friable tissue. Excessive traction may worsen injury or cause perforation. Being able to see and grasp an object is not the same as being able to remove it safely.

⚠ LINEAR FOREIGN BODIES: DO NOT APPLY TRACTION

Linear material can cause intestinal plication with pressure injury, ischaemia or perforation. Seeing an accessible end is **not** a reason to pull it. Small-intestinal involvement or questionable bowel viability often requires surgical assessment. Laparotomy-assisted endoscopic techniques have been evaluated retrospectively in selected cases (Zitsman et al., 2025); this is not routine endoscopy alone, and a retrospective comparison does not establish a universally preferred approach.

4 Clinical decision-support pathway

The sequence below organizes the questions in this guide. It is decision support, not an autonomous protocol; each step depends on clinical judgment and the resources available.

1 — Patient assessment
Stability, airway and respiratory status, hydration and perfusion; history including regurgitation versus vomiting.

2 — Object localization
Survey radiographs; abdominal imaging where gastric or intestinal involvement is suspected. Note radiolucent material may not be visible.

3 — Tissue injury & stability considerations
Duration of impaction, suspected ulceration or perforation, complications such as aspiration, anaesthetic risk.

4 — Procedural feasibility
Reachable through the lumen? Graspable? Suitable scope diameter, working length and channel-compatible instruments available? Trained operator and conversion plan in place?

5 — Select a pathway
Based on steps 1–4, discussed with the owner.

- **Endoscopic retrieval** — Selected, accessible, graspable oesophageal or gastric objects with viable tissue.
- **Surgical intervention** — Inaccessible material, linear foreign bodies with intestinal involvement, suspected perforation or compromised bowel.
- **Specialist referral** — When the equipment, expertise or support required is not available in-house.

6 — Post-retrieval reassessment
Re-examine accessible mucosa where possible, document findings, and monitor for the complications in Section 8.

Figure 1. Decision-support sequence derived from the clinical considerations in Buckley & Rozanski (2018) and Holt & Buckley (2018).

5 Endoscope specifications that matter for retrieval

When comparing endoscopes, clinics often focus on image resolution, tip diameter and working length. For retrieval, the **instrument (working) channel** deserves equal attention: it determines which accessories can pass, while the insertion tube must suit the patient.

Model	Insertion tube / distal diameter	Working length	Instrument channel	Notes
VET-6010	6.0 mm	1,000 mm	2.0 mm	Smallest diameter in the series.
VET-8015	8.5 mm	1,500 mm	2.0 mm	Longer working length with a 2.0 mm channel.
VET-9215	9.0 mm	1,500 mm	2.8 mm	Larger channel at the same working length as the VET-8015.
VET-9830	9.6 mm	3,000 mm	2.8 mm	Extended working length.
VET-1335	12.8 mm	3,500 mm	3.7 mm	Large-animal working length.

Specifications: Aohua **VET-OR1200 Series catalogue**. See also **Intriquip veterinary endoscopes**.

Channel and accessory compatibility principles

- Any accessory must be compatible with both the channel **diameter** and the scope **working length**.
- A larger channel (for example 2.8 mm versus 2.0 mm) may widen accessory options, but does not guarantee that a particular forceps, basket or snare will capture a given object.
- For each accessory, confirm outer diameter, length, intended use and **manufacturer-approved** compatibility. This guide does not list approved pairings.
- The smallest scope is not necessarily the most capable retrieval scope: narrow channels restrict instrument choice.

Roles of retrieval instruments

Instrument	General role
Grasping forceps	Grip an object that offers an edge or surface to hold.
Basket	Enclose an object that is difficult to grip.
Snare	Loop around an object or a protruding part of it.

General descriptions only. Confirm the size and manufacturer-approved compatibility of each accessory with your scope.

6 The Aohua OR-160 video processor



Aohua OR-160 with a flexible video endoscope. Image: Aohua.

Intriquip lists the **Aohua OR-160 touch-screen veterinary endoscope video processor** as an all-in-one processor and display. Specifications stated in Intriquip's listing:

- 18.5-inch touchscreen
- Image and video documentation features
- Listed by Intriquip for flexible and rigid scopes

Confirm the exact scope–processor pairing with Intriquip before purchase.

7 Endoscopy equipment selection checklist

Start with caseload and capability rather than the catalogue. A complete endoscopy setup may support selected diagnostic and therapeutic procedures only if scope, channel and accessories match the intended work.

Before choosing an endoscopy system

Print for practice planning

CASELOAD & TEAM

- [ ] How often are oesophageal and gastric foreign bodies currently referred?
- [ ] Are clinicians trained to scope and retrieve?
- [ ] Is anaesthesia and surgical backup available for conversion?
- [ ] Which patient sizes are represented in the practice?

EQUIPMENT

- [ ] Scope insertion-tube diameter suits the target patients
- [ ] Working length reaches the intended anatomy
- [ ] Channel diameter accommodates the retrieval instruments you need
- [ ] Scope–processor pairing confirmed with the supplier

ACCESSORIES

- [ ] Grasping forceps, basket and snare: diameter, length and approved compatibility confirmed
- [ ] Image and video documentation workflow agreed
- [ ] Spare and replacement accessories budgeted

SUPPORT & REPROCESSING

- [ ] Reprocessing infrastructure and protocol suitable for the scopes
- [ ] Peri-anaesthetic monitoring available (for example, a **Bionet Brio X5Vet**)
- [ ] Staff training and service support arranged with the supplier

Completed by: _____ Date: _____

Anaesthetic monitoring during endoscopy

The 2025 ACVAA monitoring guidelines recommend time-based capnography alongside ECG, non-invasive blood pressure, pulse oximetry and temperature monitoring, with continuous observation by a dedicated anaesthesia professional, for anaesthetized dogs and cats (Bailey et al., 2025).

8 After removal: monitoring and complications

An object leaving the oesophagus does not mean the injury has resolved. Inspect accessible mucosa after removal where possible, document what was seen, and communicate follow-up recommendations. A difficult extraction deserves more than a note reading "foreign body removed".

Complication to monitor for	Why it matters
Oesophagitis and ulceration	Pressure injury may persist after the object is removed.
Persistent regurgitation	May indicate ongoing oesophageal injury or dysfunction.
Aspiration pneumonia	A risk with regurgitation and with the procedure itself.
Stricture formation	A delayed complication; signs may develop after discharge.
Perforation	May be present before retrieval or caused by it; requires prompt investigation.

9 Clinical references

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5. Zitsman, J., Ford, R., Baginski, H., & Davis, G. (2025). Comparative outcomes following laparotomy-assisted endoscopic removal or gastrotomy for treatment of linear foreign bodies in dogs and cats. *Canadian Journal of Veterinary Research, 89*(4), 123–129. https://pubmed.ncbi.nlm.nih.gov/41070218/

Educational resource. This companion resource summarizes published veterinary guidance for veterinary professionals. It is not a treatment protocol and does not replace clinical judgment, patient-specific assessment, current guideline text or manufacturer instructions for use. Product mentions illustrate equipment available through Intriquip and are not claims of clinical superiority; confirm configuration, accessories and compatibility with Intriquip before purchase.

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