Detection of coins ingested by children using a handheld metal detector: a systematic review

J B Lee, S Ahmad, C P Gale

To determine if the use of a handheld metal detector (HHMD) can safely reduce the number of radiographs requested in cases of coins ingested by children, a search was performed to identify prospective studies of the ability of an HHMD to identify the presence or absence of ingested coin in children (17 years or younger). Outcome measures were presence or absence of coin on metal detector screening, and accuracy of coin localisation. Inclusion and exclusion criteria were defined. Mantel-Haenszel (fixed effect model) pooling with 95% confidence intervals (CI) was used to calculate overall sensitivities and specificities. In total, 11 studies met the inclusion criteria. The overall sensitivity of the HHMD at detecting the presence of coins was 99.4% (95% CI 98.0 to 99.9%) and accuracy at localisation was 99.8% (98.5 to 100.0%). The overall specificity of the HHMD was 100% (76.8 to 100%). Use of the HHMD is an accurate, radiation free, and cost effective method of identifying and localising coins ingested by children. An algorithm for investigating children with coin ingestion is proposed.

Foreign body ingestion by children is common. In the UK, the ingested object that most frequently results in hospital attendance is a metal coin. A postal survey of parents in the US found that 4% of children had swallowed a coin at some time. Recognised complications of unidentifed coins in the oesophagus include perforation and mediastinitis, tracheo-oesophageal fistula, and sudden death. Although the proportion of patients who are symptomatic following coin ingestion ranges from 7% to 64%, depending on the study chosen, there is consensus that absence of symptoms does not exclude the presence of an impacted coin. Hence, most patients undergo radiological investigation. The use of a metal detector to determine presence or absence of metal foreign bodies as an alternative to standard radiographs has been advocated for more than 30 years, yet, despite obvious advantages (time and lack of radiation) over standard radiographs, metal detector use has not been widely adopted in the UK.

The aim of this review was to determine if the use of a handheld metal detector (HHMD) could safely reduce the number of radiographs requested in cases of coins ingested by children.

METHODS

Criteria for selection of studies

Only prospective assessments of the ability of an HHMD to identify the presence or absence of ingested coins in children (17 years or below) were included. Outcome measures had to include either presence or absence of coin on metal detector screening, or accuracy of coin localisation. Case reports, editorials, and opinions were excluded.

Studies were scored for internal and external validity and were excluded if the following criteria were not met. (a) The gold standard (radiograph(s)) was applied in all cases regardless of result. The gold standard investigation was considered to be a chest radiograph as a minimum. Serial radiographs, performed until a coin was located or excluded, were considered an acceptable alternative. (b) The HHMD operator was blinded to the results of the gold standard investigation.

Search strategy

The following journals were hand searched by two authors (JL, SA) for issues covering January 1980–September 2004: Emergency Medical Journal (Journal of Accident and Emergency), Annals of Emergency Medicine, Pediatrics, European Journal of Pediatrics, Academic Emergency Medicine, and Journal of Otolaryngology.

Two authors (JL, CG) independently reviewed the abstracts retrieved from the search and selected which studies were to be included. If there was insufficient information from the abstract to decide, the full version of the paper was requested. Bibliographies of retrieved papers were scanned for further relevant studies.

Abbreviation: HHMD, handheld metal detector
Finally, experts in paediatric medicine, paediatric surgery, radiology, emergency medicine, and otolaryngology were contacted to identify further papers or unpublished data. In the event of disagreement the decision of a third author (SA) was final.

Search results and study quality
The search strategy employed retrieved 1039 citations, of which 12 articles met the criteria for the review. Agreement was total between authors for the 12 studies chosen for inclusion. The quality of included studies was good but this could only be concluded after contact with the authors for six studies, because of inadequate reporting of methodology. All studies were prospective, blinded, and used an appropriate reference test. The study characteristics have been tabulated (table 1).

Data extraction and analysis
Data was independently extracted from the papers by two authors (JL, SA) and doubly entered into Meta-DiSc software (version 1.1.1). Where studies included all types of ingested metal foreign body, only the subset data for coins was used to calculate sensitivity at coin identification, and accuracy of localisation. Only data from studies purely investigating ingested coins was used to calculate specificities. Where studies included patients referred from secondary centres with radiologically proven oesophageal coins, those patients were excluded from the analysis of ability to identify coin presence, but were still included in analysis of accuracy of coin localisation (provided this was confirmed on a second radiograph) as coins could have moved en route. Only data from doctor or radiographer operators, with prior instruction on how to use the HHMD, however brief, was used in the pooled analysis. If studies localising coins used a variety of descriptors of location areas, the areas were dichotomised into abdominal (below the xiphisternum) or non-abdominal (xiphisternum or above).

The authors of one study, Arena et al.,27 reported a 100% sensitivity and specificity using the HHMD on 28 children but could not be contacted. Owing to the inadequate reporting of type of metal objects ingested, data for coins alone could not be extracted, and this paper was excluded. Nine studies

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**Table 1  Characteristics of included studies**

<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Patient group</th>
<th>Study type</th>
<th>Reference standard</th>
<th>Outcome measures</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muensterer OJ et al, 2004, Germany</td>
<td>65 consecutive children presenting to an ED over 20 months with suspected or witnessed MFB ingestion</td>
<td>Diagnostic</td>
<td>Serial radiographs (abdomen +/- chest +/- neck)</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>Uzman Tracker IV model. Coins present in 25 patients. 2 false positives</td>
</tr>
<tr>
<td>Scholamone J et al, 2004, Austria</td>
<td>53 consecutive children presenting to an ED with suspected MFB ingestion</td>
<td>Diagnostic</td>
<td>Chest radiograph</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>MV9 Proxxon model. 1 patient refused 2nd radiograph and was excluded from the study. Coins present in 34 patients</td>
</tr>
<tr>
<td>Younger R et al, 2001, US</td>
<td>26 children referred from EDs with radiologically proven oesophageal coins (at least 6 hours earlier)</td>
<td>Diagnostic</td>
<td>Repeat radiographs of chest and abdomen</td>
<td>MFB localisation to chest or abdomen</td>
<td>Garrett Super-Scanner model. Operators received &lt;1 min of training. Coins present in 9 patients</td>
</tr>
<tr>
<td>Gooden E et al, 2000, Canada</td>
<td>10 children presenting to an ED with suspected foreign body ingestion, or transferred from another centre</td>
<td>Diagnostic</td>
<td>Repeat radiographs of chest, neck, and abdomen</td>
<td>MFB localisation to chest or abdomen</td>
<td>Heiman MHG model. Investigators were not blinded to radiographs of transferred patients. Coins present in 9 patients</td>
</tr>
<tr>
<td>Doraiswamy NV et al, 1999, UK</td>
<td>231 children presenting to an ED with suspected MFB ingestion</td>
<td>Diagnostic</td>
<td>Chest radiograph</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>Adams AD 18 model. Coins present in 60 patients. 6 false positives. MFBs were only missed in the inexperienced group</td>
</tr>
<tr>
<td>Seikel K et al, 1999, US</td>
<td>176 consecutive children presenting to 2 children’s hospitals with suspected MFB ingestion examined by “inexperienced” scanners, 140 of whom were also seen by “experienced” scanners</td>
<td>Diagnostic</td>
<td>Chest radiograph</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>Garrett Super-Scanner model. Coins present in 60 patients. 6 false positives. MFBs were only missed in the inexperienced group</td>
</tr>
<tr>
<td>Tidby B et al, 1996, UK</td>
<td>20 children presenting to an ED with suspected foreign body ingestion</td>
<td>Diagnostic</td>
<td>Serial radiographs (chest +/- abdomen +/- neck)</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>Adams AD 15 model. Coins present in 8 patients</td>
</tr>
<tr>
<td>Sachetti A et al, 1994, US</td>
<td>23 children presenting to an ED with suspected MFB ingestion</td>
<td>Diagnostic</td>
<td>Chest radiograph</td>
<td>Presence or absence of MFB on scan. MFB localisation to chest or abdomen</td>
<td>Garrett Super-Scanner and Enforcer G2 model. Coins present in 6 patients. Backpacker-2 TR model. Coins present in 27 patients. Areas used to document localisation were: above clavicles, substernal, or abdominal</td>
</tr>
<tr>
<td>Biehler JL et al, 1993, US</td>
<td>19 consecutive children presenting to an ED with suspected coin ingestion and 11 children referred with proven oesophageal coin</td>
<td>Diagnostic</td>
<td>Serial radiographs (chest +/- abdomen +/- lateral chest)</td>
<td>Presence or absence of coin on scan. Coin localisation to chest or abdomen.</td>
<td>Garrett Super-Scanner model. Coins present in 11 patients. 1 coin in the rectum not identified. Only the anterior neck, chest, and abdomen were scanned</td>
</tr>
<tr>
<td>Ras S et al, 1992, US</td>
<td>14 consecutive children presenting to an ED with suspected coin ingestion</td>
<td>Diagnostic</td>
<td>Chest and abdominal radiographs</td>
<td>Presence or absence of coin on scan. Coin localisation to chest or abdomen</td>
<td>Garrett Super-Scanner model. Coins present in 11 patients. 1 coin in the rectum not identified. Only the anterior neck, chest, and abdomen were scanned</td>
</tr>
</tbody>
</table>

MFB, metal foreign body.
remained for analysis of the ability of the HHMD ability to identify coins, and 11 studies remained for the analysis of its ability to localise coins (table 2). Mantel-Haenszel (fixed effect model) pooling with 95% confidence intervals was used to calculate sensitivities and specificities (fig 1). Handling of zeros was performed by adding 0.5 to zero cell studies. The χ² test was performed to assess study heterogeneity. Predictive values, likelihood ratios, and diagnostic odds ratios are not useful in this clinical setting and were therefore not calculated.

RESULTS
The included studies showed no evidence of heterogeneity for sensitivity (χ² = 8.0, p = 0.43) or specificity (χ² = 0, p = 1.0). The overall sensitivity of the HHMD at detecting the presence of coins was 99.4% (95% confidence interval (CI) 98.0 to 99.9%) and accuracy at localisation was 99.8% (98.5 to 100.0%). The overall specificity of the HHMD was 100% (76.8 to 100%).

DISCUSSION
Most metal detectors work on the basis that metal objects cause a disturbance in an electromagnetic field, passing between a transmitter and receiver, triggering an audiovisual signal. When attempting to identify an ingested metal foreign body with an HHMD, false positive results may be caused by metal implants and wires remaining in situ following thoracic surgery, nearby wall fixtures, trolleys, patient or parental jewellery, metal clasps, zips, buttons, or belt buckles. Ideally, for the scan, a child should wear a gown, and should stand or be held away from walls. The majority of studies identifying ingested metal foreign bodies have effectively employed techniques of vertically scanning the chest from chin to xiphoid, horizontally across the abdomen, and horizontally down the back.

Of the 11 studies included in our final analysis,18–28 some are worthy of further scrutiny because they serve to highlight potential limitations of the ability of the HHMD to detect metal foreign bodies. Schalamon et al23 correctly identified all 32 coins ingested by children in their study, using an HHMD. However, 8 of 15 non-coin metal foreign bodies were not identified, including two button batteries and a needle. Similar difficulties have been reported by other investigators,18,26 and the message appears clear that HHMDs may not be reliable at excluding the presence of metal foreign bodies other than coins. The study of Basset et al22 reported a coin incorrectly localised by an operator with prior training in the use of an HHMD. Muensterer et al25 reported a coin not identified by HHMD scanning. The only other reported missed coin, in a study by Ros and Cetta,28 was located in the rectum. Their technique of only scanning the neck, chest, and abdomen anteriorly may explain this. Studies that have included the sacral area in the scan have successfully identified rectal coins.17,18,21

Three studies reported false positive results. Doraiswamy et al21 had eight false positive scan results when using the HHMD to detect suspected ingested metal foreign bodies in 231 children. After excluding children with metal implants (two sternotomy wires), and removing likely external sources of false positives (mother's ring, a trouser zip, a coin in the pocket, a metal button, a belt buckle, and in two cases, a steel chair), re-scanning proved negative in all cases. Seikel et al24 and Muensterer et al23 reported eight false positives between them but gave no further details. Seikel et al, however, did report a case of ingested aluminium not seen on the radiograph but clearly identified by HHMD scanning. The low radiodensity of aluminium makes it almost "invisible" on radiographs, and the superiority of an HHMD at identifying ingested aluminium objects has been documented elsewhere."20b-22b

Seikel et al24 attempted to show that no training was required to be able to use the HHMD effectively. A convenience sample of non-doctors (such as porters and receptionists), with no previous experience in the use of a HHMD, followed written instructions and scanned a maximum of one child each. This "inexperienced" group missed one coin and incorrectly localised 2 of 124 coins. The "experienced" group (doctors with up to 1 hour's practice), missed no coins and localised all objects correctly. Only Basset et al22 reported a coin incorrectly localised by an operator with prior training in the use of an HHMD. However, this study was designed to show that a minimum of training is necessary to allow the HHMD to be used effectively, with each operator given a demonstration of its use lasting <1 minute. Incorrect localisation has not been reported in any study with "experienced" operators. The use of the HHMD is simple, but familiarity with its use appears beneficial. At present, no validated training programme exists on how to use the HHMD to identify ingested coins. Logically, any training should include a discussion of potential causes of false positive and false negative results, and a demonstration of the basic features of the HHMD. Subsequently, a "see one, do one (supervised), teach one" approach appears well suited to the development of proficiency with the technique.

Applying meta-analysis techniques to diagnostic studies is a relatively recent concept, and guideline developers31,32 have expressed concern over study heterogeneity and poor reporting of study methodology. In such cases, the statistics are complex and the validity is questionable. However, when diagnostic studies have similar methodologies and there is homogeneity of results, as is the case here, the proportions of the studies can be simply added together to derive sensitivity and specificities.34 The pooled estimate of sensitivity of the ability of the HHMD to detect ingested coins was 99.4% (95% CI 98.0% to 99.9%) and its accuracy at localisation was 99.8% (98.5 to 100.0%). The pooled specificity at identifying swallowed coins was 100% (76.8 to 100%), but patient numbers were low because of exclusion of trials investigating all metal foreign bodies.

![Figure 1: Sensitivity graph of HHMD at identifying coins ingested by children from included studies.](http://emjonline.com)
Statistics can complicate even the most straightforward of matters. Quite simply, of 351 children with radiographically identified coins, only two were not identified by the HHMD, with plausible explanations offered for both. Only one of 417 coins identified was incorrectly localised, by an operator with ≤1 minute of instruction. Of contacted authors who continue to use the HHMD, none could provide new data because they no longer perform confirmatory radiographs on patients with negative scans or those with positive scans below the epigastrium. Combined, these authors19 22 25 26 28 represent a period of over 20 years of HHMD investigation of coin ingestion by children in the emergency department. None could recall a complication from a missed coin. Although anecdotal, complications from ingested coins missed by the HHMD must be rare, and have not yet been reported.

Children with coins located at the level of the xiphisternum should have confirmatory radiographs to exclude impaction at the gastro-oesophageal junction, whereas children with coins localised below the xiphisternum can forego radiographic investigation. Accurate localisation of coins to the abdomen is important because such cases can be managed conservatively. We could find only one report of a coin below the diaphragm that required surgical intervention.35 The patient was a 22 year old woman who had ingested an American "penny" 3 weeks earlier. The coin had caused a perforation of the oesophagus that required surgical intervention.35

Few UK studies have documented the incidence of ingested coins excluded by a HHMD to cover the initial cost of the device.31 36 Other centres have quoted the number of eligible children not enrolled, raising the possibility of selection bias. Finally, the ability to detect a coin may be dependent upon the device chosen or the composition of the coin. However, sensitivities of 100% have been quoted in the literature.23 37 Thus, it would take only four cases (based on the cost of a single radiograph) of ingested coins excluded by a HHMD to cover the initial cost of the device, with all subsequent negative scans or scans localising coins to the abdomen representing direct savings. Few UK studies have documented the incidence of children presenting to the emergency department with suspected coin ingestion. Doraiswamy et al11 noted 124 in 18 months in Glasgow. By comparison, Tidey et al35 noted only 13 in 1 year in Brighton, but acknowledged that the majority would have been seen at the local children's hospital.

The benefit of reduced patient time spent in the department for those foregoing radiological investigation will be obvious not only to the child and parents, but to all facing the current 4 hour target.38 Others may identify a reduction in the number of children exposed to potentially harmful ionising radiation as the main advantage of the HHMD. A telephone and internet survey of UK emergency consultants conducted by us in October 2004 revealed that of the 50 departments sampled, only five possessed a metal detector (unpublished data). The commonplace reasons given for not using a HHMD were cost and doubt over its accuracy. This

Table 2  Extracted data from included studies examining the ability of the handheld metal detector to identify and localise ingested coins in children

<table>
<thead>
<tr>
<th>Authors</th>
<th>Coins correctly identified</th>
<th>Coins incorrectly localised to chest or abdomen</th>
<th>Coins correctly localised to chest or abdomen</th>
<th>MFBs correctly excluded</th>
<th>False positives for an ingested MFB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muenterer C et al</td>
<td>25</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Schalamon J et al</td>
<td>32</td>
<td>0</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bassett KE et al</td>
<td>53</td>
<td>1</td>
<td>81</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Doraiswamy NV et al</td>
<td>146</td>
<td>0</td>
<td>138</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>Seikel K et al</td>
<td>50</td>
<td>0</td>
<td>50†</td>
<td>0†</td>
<td>2†</td>
</tr>
<tr>
<td>Tidey B et al</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Sachetti A et al</td>
<td>11</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Biehler JL et al</td>
<td>16</td>
<td>0</td>
<td>21†</td>
<td>0†</td>
<td>3†</td>
</tr>
<tr>
<td>Ros S et al</td>
<td>10</td>
<td>1</td>
<td>10†</td>
<td>0†</td>
<td>3†</td>
</tr>
<tr>
<td>Gooden E et al</td>
<td>–</td>
<td>–</td>
<td>9†</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Younger R et al</td>
<td>–</td>
<td>–</td>
<td>26</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>351</td>
<td>2</td>
<td>417</td>
<td>1</td>
<td>101 (14*)</td>
</tr>
</tbody>
</table>

*Studies investigating suspected coin ingestion only; †only data for localisation to the chest was collected; N/A, data could not be extracted from paper and author could not be contacted.
view may have been based upon the historically higher costs of the HHMD and wide confidence intervals around sensitivity values published in small studies. Evidence has now been presented to challenge both points. In fig 2, we present a proposed algorithm for the investigation of a child with a suspected ingested coin.

CONCLUSION

The HHMD is accurate, radiation free, and cost effective at identifying and localising coins ingested by children. The use of a HHMD by all UK emergency departments is overdue. Personnel who operate the device should have a demonstration and practice session before use, and be alerted to possible causes of false negative and false positive results.

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Authors’ affiliations
J B Lee, S Ahmad, Leeds General Infirmary, Leeds, UK
C P Gale, Pinderfields General Hospital, UK

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