

Case Report

Squid jig fishing lure foreign body in the right external auditory canal:**A case report****ABSTRACT**

Background: Foreign bodies in the external auditory canal (EAC) are commonly encountered in clinical practice. Sharp foreign bodies, however, are rarely reported and pose a unique challenge due to the risk of injury to the canal skin and tympanic membrane during extraction. Fishing lures with multiple hooks represent an unusual and complex variant of sharp EAC foreign bodies. **Case Presentation:** A 21-year-old male presented to the emergency department with a squid fishing lure inadvertently inserted into his right EAC. The lure featured two tiers of hooks (twelve hooks per tier) directed outward, with several hook tips embedded in the canal skin. The patient reported right ear pain without bleeding or hearing loss. Extraction was performed under general anesthesia using endoscopic guidance. The hook tips were bent inward with forceps before the lure was carefully withdrawn. Postoperatively, skin excoriation of the outer third of the EAC was observed with no tympanic membrane perforation. A three-month follow-up, the EAC appeared clear with no complications. **Conclusion:** Sharp EAC foreign bodies such as squid fishing lures require individualized extraction strategies. Bending the hook tips prior to withdrawal minimizes canal wall trauma. General anesthesia and endoscopic guidance are recommended for complex sharp foreign bodies to ensure precise manipulation and patient safety.

Keywords: external auditory canal, foreign body, fishing hook, endoscopic extraction, sharp foreign body

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INTRODUCTION

Foreign bodies in the external auditory canal (EAC) are common clinical presentations, particularly among children but occasionally occurring in adults due to accidental or self-inflicted causes. These cases pose varying degrees of diagnostic and management challenges, depending on the type, shape, and location of the object.^{1,3-14} There is no general agreement or literature describing how to remove foreign bodies from the EAC. Contact with the EAC's skin during sharp foreign object extraction should be minimized, especially near the tympanic membrane.²⁻⁴ Sedation is sometimes necessary if the patient is uncooperative or if removal of the foreign body could potentially cause trauma to the EAC.⁴⁻¹⁰ Inappropriate or repeated extraction attempts may increase the risk of complications, such as canal laceration, infection, or tympanic membrane perforation.

This case report aims to explore the diagnosis and endoscopic extraction of an unusual foreign body — a squid jig fishing lure — lodged in the right EAC of a 21-year-old male, highlighting the evidence-based approach in managing sharp foreign bodies in the ear.

CLINICAL QUESTION

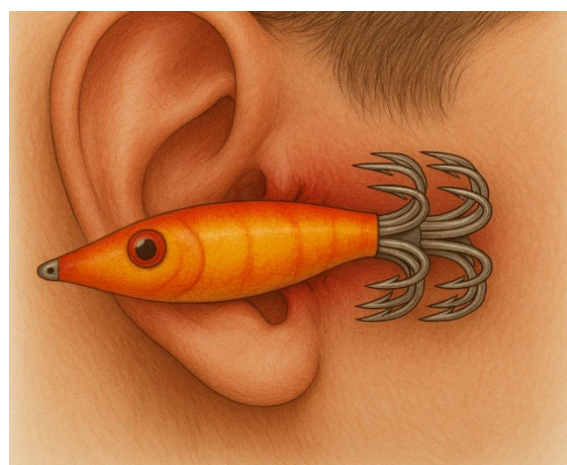
In patients presenting with sharp multi-hooked foreign bodies in the external auditory canal (P), does endoscope-assisted extraction under general anesthesia with prior hook-tip modification (I), compared to conventional bedside extraction techniques (C), result in lower rates of iatrogenic canal wall injury and complete foreign body removal (O)?

CASE REPORT

A 21-year-old male came to the Emergency room (ER) complaining of pain in the right ear after a sharp fishing lure Became lodge in the right EAC. Ear discharge and hearing loss were denied. Upon physical examination, a fishing lure was found dangling out from the right EAC, shown in **Fig 1**, piercing the EAC skin as illustrated in **Fig 2**. Active bleeding, discharge, and edema were not present. Tuning fork examination indicateds conductive hearing loss on right ear. The patient was hospitalized and planned for extraction under general anesthesia.

Intravenous medication was given including fluid drips, antibiotics and steroids

Fig 1. Clinical photograph of a squid fishing lure



dangling out from the right EAC.

Fig 2. Illustration of squid jig fishing lure in 1/3 outer of EAC.

Endoscopic-guided extraction of the sharp foreign object was performed the following day under general anesthesia. During extraction, a clamping instrument was used to bend the sharp tips of the fishing lure inwards, away from the EAC skin. At certain points where the sharp tips of the fishing lure had pierced the skin of the external auditory canal (**Fig 3**), the skin was gently released to avoid further trauma. A complete removal was successful without major damage to the EAC. The patient was discharged 1 day after extraction with oral antibiotics and steroids.

The excoriation of the external auditory canal which resulted from the foreign object healed well. Evaluation 1 week after the extraction showed no sign of complication (**Fig 4**).



Fig 3. Squid jig fishing lure extraction process. Notice the barb (arrow) bent away from the EAC skin to prevent further injury.



Fig 4. Right EAC 1 week after extraction showing full resolution.

METHODS

A literature review was conducted using PubMed, Google Scholar, and Science Direct databases. Keywords used included: “ear canal foreign body”, “sharp ear foreign body”, “ear foreign body extraction”, “fishing hook”, “endoscopic extraction”, and “outer ear trauma”. Articles published in English within the last 10 years, discussing management and outcomes of foreign bodies in the EAC, especially sharp or complex objects, were included in the report.

However, articles not available in full text, non-English publications, and studies not involving human subjects were excluded from the study.

RESULTS

From the search, several relevant articles were reviewed. Most described successful extraction techniques for ear foreign bodies in outpatient or emergency settings, using forceps, suction, hooks, or irrigation. Some cases Reported required surgical intervention or endoscopic assistance. A summary of reviewed articles is shown in **Table 1**.

DISCUSSION

Foreign bodies in the external auditory canal (EAC) represent one of the most frequently encountered otological emergencies across all age groups.¹ While inorganic, blunt objects such as beads, pebbles, and erasers account for the majority of cases, sharp foreign bodies constitute a distinct, uncommon, and technically demanding subset that carries a significantly heightened risk of iatrogenic injury during extraction.^{1,5} Fishing hooks and lures as EAC foreign bodies have rarely been described in the literature,¹⁴ and the present case is, to our knowledge, the first reported instance of a squid fishing lure — characterized by a rigid body carrying two circumferential tiers of twelve outward-directed hooks — retained within the human EAC.

The patient, a 21-year-old male, had inadvertently inserted the lure into his right EAC and presented with localized ear pain as the sole complaint. The absence of active bleeding, otorrhea, and hearing loss on presentation suggested that the initial canal skin injury was likely superficial. Nonetheless, the design of the lure inherently precluded safe bedside

Table 1. Summary of Previously Published Case/Study of Ear Foreign Body Management.

No.	Author(s)	Study	Patient details	Presentation	Treatment and Outcome
1.	Prasad & Harley ⁷	Retrospective chart review	- There were 155 children in the study, of which 90 (58%) were male and 65 (42%) were female. - The age range of actual patients reviewed was 2–17 years of age, with a median age of six.	- There were more than 30 different types of FBs and seven indeterminate objects. - The six most common FBs were paper, beads, pebbles, cotton, erasers, and plastic.	- The three most common instruments employed for removal were micro-alligator forceps, right-angle hook, and suction. - FB extraction was accomplished in the ENT clinic setting in 112 children (72%), in the ENT surgical suite in 35 children (23%), in the ED in 4 children (2.5%), and not listed in 4 children (2.5%). - The most common reason for extraction in the OR was the failed prior attempts due to child being too fearful, anxious, uncooperative (14), failed attempts in otolaryngology clinic (8), incidental discovery (7), FB too inaccessible for clinic removal (1) - There was a total of two major complications from failed prior attempts, both being tympanic membrane perforations. There were 54 minor complications, the majority of which were comprised of minor abrasions and infections.
2.	Szleper & Bruzgielwicz ¹²	Case report	27-year-old male	- A plastic ball used as a bullet in a toy weapon had entered the right ear canal at the age of 12.	- After local anesthesia of the skin of the auditory canal with a 10% solution of lidocaine spray, the foreign body and earwax mass were activated with a suction pump, then – using a blunt ear hook – it was extracted outside.

extraction. When a squid lure is introduced into the canal, its two tiers of outward-pointing, barbed hooks engage the canal skin, generating a ratchet-like anchorage that prevents withdrawal by simple traction. This mechanism also precludes the use of conventional extraction techniques such as irrigation, suction, or blind hook maneuvers, all of which would risk advancing the barbs more deeply into the canal wall or toward the tympanic membrane.

Identification of the foreign body in this case was straightforward, as the proximal body of the lure remained visible at the meatal entrance and the hook geometry could be assessed directly. Because the object had been introduced at low velocity and was clearly visualizable on otoscopy, cross-sectional imaging was not required for diagnosis.¹⁵ Radiological investigation, including plain X-ray or computed tomography, is reserved for objects introduced at high velocity, those not identifiable on direct inspection, or cases where deep penetration toward the middle ear or temporal bone is suspected.^{5, 15}

Clinical examination confirmed the presence of a multi-tiered sharp lure with excoriation of the EAC skin caused by the penetration of several barbed tips. The tympanic membrane could not be assessed owing to obstruction by the lure body. Although the patient denied prior hearing symptoms or otorrhea, a pre-existing tympanic membrane perforation could not be entirely excluded prior to extraction.

There is no consensus in the literature regarding a standardized protocol for the removal of sharp foreign bodies from the EAC.³ The guiding principle in all such cases is to minimize contact between the instrument and the canal skin, particularly in proximity to the tympanic membrane, where inadvertent trauma may result in perforation or ossicular injury.³ The decision in this case to proceed under general anesthesia was based on three interdependent considerations: the complex multi-hook geometry of the object, the anticipated duration of the procedure required to sequentially address all 24 hook tips, and the imperative to eliminate any involuntary patient

movement that might inadvertently advance the hooks into the medial canal or perforate the tympanic membrane. Current guidelines recommend that foreign body removal attempts be limited to one or two before referral to an otolaryngologist, and it is well established that approximately 23% of EAC foreign body cases ultimately require removal in the operating theatre under general anesthesia.³

The extraction technique was guided by the specific anatomy of the lure rather than by generic protocols. Under endoscopic magnification, each hook tip of the first tier was sequentially bent medially using fine forceps so that the outward-pointing barbs were redirected away from the canal skin. The second tier was treated identically. Once all tips had been neutralized, the lure was withdrawn en bloc in a single, controlled movement. This approach is conceptually analogous to the advance-and-cut or string-pull techniques described for the removal of embedded cutaneous fishhooks, in which the hook geometry is modified before withdrawal to avoid further tissue trauma.⁷ Endoscopic visualization was indispensable in this context: it allowed precise identification of each embedded tip, confirmed complete disengagement of the hooks before traction was applied, and provided real-time feedback to prevent inadvertent injury to the medial canal or tympanic membrane.

Postoperative management followed established principles for traumatic EAC injuries. Systemic antibiotics (ceftriaxone intravenously, followed by oral cefixime) and systemic corticosteroids (methylprednisolone) were administered to prevent secondary infection and to limit post-traumatic oedema of the canal skin. Tetanus prophylaxis with human tetanus immunoglobulin was administered in view of the marine-contaminated puncture wounds, consistent with wound management recommendations for marine-related injuries.⁸ An antibiotic ointment-impregnated canal pack was inserted to maintain a moist wound environment, prevent crust formation, and reduce the risk of secondary infection of the excoriated skin surface.

The combination of systemic and local antimicrobial coverage is in line with recommendations for cases involving laceration or trauma to the EAC.³

Complications of EAC foreign body removal include canal skin laceration (16%), otitis externa (6%), and tympanic membrane perforation (2%), with complication rates rising substantially with the number of failed extraction attempts.^{1, 11} In the present case, only superficial excoriation of the outer third of the canal was identified at the conclusion of the procedure, and the tympanic membrane was confirmed to be intact. At the three-month follow-up, the EAC was fully patent with healthy skin and no evidence of canal stenosis, granulation tissue, or otitis externa. The favorable outcome is attributable to the combined effect of individualized technique, general anesthesia providing complete patient immobility, and endoscopic guidance ensuring precise and atraumatic manipulation.

This case highlights a fundamental principle in the management of unusual EAC foreign bodies: the extraction strategy must be tailored to the specific mechanical properties and geometry of the object rather than to the generic category of "sharp foreign body." A standardized approach that may succeed for a single embedded fishhook would be wholly inadequate — and potentially hazardous — for a multi-tiered lure with 24 independently barbed hooks. Systematic preoperative characterisation of the foreign body, thoughtful instrument selection, and the judicious use of anaesthesia and endoscopy are the cornerstones of a safe and effective outcome.

CONCLUSION

Squid jig fishing lure foreign body in EAC is a rare clinical occurrence. A case of a 21-year-old male was reported with a squid jig fishing lure lodged in the right EAC. Extraction was performed under general anesthesia, endoscopy-assisted, and clamping instruments were used to bend the sharp barbs away from the EAC skin to minimize injury. No complications were found after the extraction procedure.

This case illustrates the effectiveness of an endoscopic-assisted approach under general anesthesia for the safe removal of a sharp fishing lure. Such management strategies should be considered in similar cases to minimize complications and ensure complete removal.

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REFERENCE

1. Donne AJ, Davies K. Foreign bodies in the ear, nose and throat. In: Watkinson JC, Clarke RW, editors. *Scott-Brown's Otolaryngology: Head and Neck Surgery*. 8th ed. Vol. 2. Boca Raton: CRC Press, Taylor and Francis Group; 2018. p. 385–6.
2. Rafique M, Shaikh AA, Siddiqui AH. Foreign bodies in ear – its type, diagnosis and management. *J Liaquat Univ Med Health Sci*. 2015; 14(2):86–9.
3. Lotterman S, Sutton AE, Hohman MH. Ear foreign body removal. [Updated 2025 Jan 22]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 [cited 2025 May 9]. Available from: <https://www.ncbi.nlm.nih.gov/sites/books/NBK459136/>
4. Afolabi OA. Foreign body in the ear: a review of methods of management. *Savannah J Med Res Pract*. 2019; 8(1):1–7.
5. Leslie CO. Foreign bodies of the ear, nose, and throat. *Emerg Med Clin North Am*. 2019; 37:121–30.
6. Olajide TG, Ologe FE, Arigede OO. Management of foreign bodies in the
7. ear: a retrospective review of 123 cases in Nigeria. *Ear Nose Throat J*. 2020. doi:10.1177/0145561320938166.
8. Prasad N, Harley E. The aural foreign body space: a review of pediatric ear foreign bodies and a management paradigm. *Int J Pediatr Otorhinolaryngol*. 2020; 132:109924.
9. Zewdu D, Eanga S, Hunie M. The practice of foreign body removal from the ear, nose, and upper esophageal in children in

- Ethiopia: a retrospective descriptive study. *Laryngoscope Investig Otolaryngol.* 2021; 6:1316–20.
10. Mazumder JA, Sarker RI, Delwar AHM. Ear foreign body: a study of 148 cases. *Med Today.* 2017;29(2):5–8.
 11. Ogah SA. Aural foreign bodies: a retrospective study of 162 patients. *Pak J Med Dent.* 2018;7(3):9–11.
 12. Pokharel A. Foreign bodies in ear, nose and throat: an experience from a tertiary care hospital in central Nepal. *Nepal Med Coll J.* 2019;21(4):276–82.
 13. Szleper A, Bruzgielwicz A. Long-standing foreign body in the external auditory canal – case report. *Index Copernicus Int.* 2020.
 14. Awad A, Eltaher M. ENT foreign bodies: an experience. *Int Arch Otorhinolaryngol.* 2017; 22:10.1055/s-0037-1603922.
 15. Oyama LC. Foreign bodies of the ear, nose and throat. *Emerg Med Clin North Am.* 2019;37(1):121–30.