

CASE REPORT

The Silent Choke: A Fatal Case of Cafe Coronary Unveiled

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ABSTRACT

Imagine someone enjoying a meal, perhaps a bit too much to drink, when suddenly they go silent, stand up, and then inexplicably collapse. This is the classic presentation of a cafe coronary, a condition where a piece of food completely obstructs the airway by lodging in the laryngopharynx and larynx. Unlike typical choking, there are often no dramatic struggles. The person might turn blue, cough violently for a moment, and then die relatively quietly. While it can be mistaken for a sudden heart attack, the true cause of death is generally attributed to reflex vagal inhibition of the heart, not a cardiac event. Autopsy often reveals a sizable, poorly masticated food bolus lodged in the larynx. A crucial detail is the absence of typical choking signs, which can be attributed to the deadening effect of high blood alcohol content on the gag reflex.

KEYWORDS

• Cafe coronary • Choking • Reflex vagal inhibition

INTRODUCTION

Food can enter the larynx in two primary ways: either during the act of swallowing or through regurgitation from the stomach. When food is aspirated directly from the mouth during swallowing, it's usually quite clear what happened. Undigested food is often found

in the airways, and there's typically a history of the death occurring while the person was eating. While more common in the elderly and those with mental health conditions, this can happen to anyone. A striking example of this is the "café coronary" syndrome. In these cases, seemingly healthy individuals, often well-

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nourished businessmen, would suddenly and unexpectedly die during a meal. Initially, it was believed to be a heart attack because there were no typical signs of respiratory distress or asphyxia. However, autopsies consistently revealed a large piece of food, frequently steak, lodged in the pharynx or larynx. In any choking incident involving food, the obstructing item can be surprisingly large, such as an entire pancake, a whole tangerine, or substantial quantities of meat, fruit, or vegetables.¹

An airway obstruction, termed a bolus, typically lodges at the laryngeal entrance, specifically within the aditus inferior to the epiglottis. Its occurrence is often linked to inhibited nerve reflexes, such as those present during alcohol intoxication. The designation "café coronary" stems from its frequent association with dinner settings and considerable alcohol intake. Characteristic signs when a bolus is in the larynx include the victim partially rising from a seated position, clutching their throat, and developing cyanosis, leading to potential misidentification as a myocardial infarction. Bolus-related deaths are also observed in populations like drug addicts. The history, if available, is a better guide in such cases.

The autopsy will reveal the foreign body that caused the airway occlusion, located in the mouth, larynx, or trachea.

THE CASE

This report details the post-mortem examination of a 30-year-old male at the Civil Hospital Faridabad mortuary. The individual had a history of eating after consuming alcohol. The body was fresh, measuring 154 cm, with an average build and no significant external injuries. On dissection of neck and removal of laryngotracheal structures, a semi chewed bolus of food was found impacted just below the epiglottis completely blocking the laryngeal opening (*Figure 1*). On removing the food bolus, mucosal congestion and multiple petechial haemorrhages were present over this area. Stomach contained about 150 cc of yellowish brown semi digested food material admixed with mucoid material. Stomach mucosa was pale. No peculiar smell was present. The heart was weighing 200 grams. Grossly heart was normal. On dissecting the heart with inflow and outflow methods, heart along with coronaries was within normal limits.

All the solid organs were within normal limits. The cause of death was given as asphyxia due to choking.



Figure 1: Blockage of the larynx by a semichewed bolus of food in alcoholic patient. The arrow indicating bolus had just been swallowed and was not regurgitated from the stomach

DISCUSSION

There are several factors increase a person's risk of café coronary syndrome. One significant factor is the misjudgment of the size of the food bolus being swallowed, often due to intoxication from alcohol or sedation from tranquilizers.²

In many instances, law enforcement personnel initially identify the apparent cause of death as a diagnosis other than choking, such as a myocardial infarction (heart attack), which aligns with the present case. Statements from the deceased's relatives indicated a history of chronic alcoholism and alcohol consumption with food prior to sleep on the night of death. Their suggestion of a heart attack as the cause is consistent with the typical presentation and circumstances observed in a café coronary event.

In these types of fatalities, the typical signs of oxygen deprivation are often absent. Instead, victims frequently simply slump in their chairs, deceased. This suggests the cause of death is cardiac arrest, likely triggered by an overstimulation of the parasympathetic nervous system. This overactivity stems from the irritation of the laryngeal or pharyngeal

lining, a phenomenon known as the reflex cardiac inhibition.¹

The presence of gastric contents within the air passages is considerably less diagnostically significant than the finding of freshly swallowed food. A more definitive conclusion can only be reached in circumstances involving acute alcoholism, although even in these instances, absolute certainty typically proves elusive.

A study was done on a total of 141 cases at the Dade County Medical Examiner's Office, Miami. The overall risk of sudden death from a cafe coronary was calculated to be 0.66 per 100,000 population. The type of food most often associated with the fatal cafe coronary in 74% of the free-roaming adults was meat. In 130 cases where food was found at autopsy, the obstruction was most often infraglottic (68%). Whereas the major predisposing factors are alcohol and drugs, patients confined to extended medical care facilities are also at risk.³

The case series, involving nine individuals, formerly published highlighted critical factors contributing to fatal food bolus obstruction. The cases demonstrated an ability to accommodate an exceptionally large amount of food in the mouth, coupled with a notable disregard for proper eating etiquette. Dental status was also implicated, as the obstructing food showed minimal to no evidence of proper chewing. Furthermore, alcohol played a significant role, with four victims exhibiting high blood alcohol levels ranging from 0.17% to 0.31%. Interestingly, the obstruction was not evident upon immediate oral examination and was only discovered during post-mortem en bloc removal of the neck organs.⁴

An earlier case report documented an unwitnessed death attributed to café coronary syndrome. A 70-year-old edentulous man was discovered deceased in his bed the morning after having dinner with his children. The autopsy revealed a blob of mucoid secretions in his right nostril and a 21-gram piece of banana lodged in his laryngopharynx, completely blocking the airway.⁵

In a comparable case report, an approximately 40-year-old adult male was discovered deceased on his bedroom floor, lying in a prone position. Alongside him, a tiffin box containing meat and rice, as well as a half-empty liquor bottle, were found. Upon

examination, a large piece of meat, measuring 7×3×2 cm, was located in the lower larynx. Notably, there were no features indicating asphyxia.⁶

In another documented case, a 65-year-old woman was discovered deceased in her bed, having last been seen eating dinner the previous evening. The autopsy revealed an 18-gram piece of banana lodged in her laryngopharynx, completely obstructing her airway. She was edentulous and had a history of psychiatric conditions.⁷

Another case involved a young adult male Indian Ocean Bottlenose dolphin (*Tursiops cf aduncus*) found floating in an estuary near Adelaide, South Australia. An autopsy revealed the cause of death was an obstruction of the upper aerodigestive tract by a 660mm Cobbler Carpetshark (*Sutorectus tentaculatus*). While the death could simply be due to over-enthusiastic feeding, neurological impairment from organochlorine pesticides and heavy metal poisoning is also a possibility.²

Across all case reports, a consistent theme emerged: the critical need for greater awareness regarding deglutition difficulties and psychiatric illness, particularly among the elderly.

CONCLUSION

To prevent deaths from café coronary syndrome, modifying eating habits is crucial. Edentulous elderly individuals, in particular, should be aware of measures like eating smaller portions, pre-munching, crumbling food, and avoiding rapid gulping. Furthermore, knowing emergency treatments such as the Heimlich maneuver can save lives if such an event occurs.⁸

For forensic pathologists, a litmus test on lower respiratory tract secretions can rule out gastric aspiration. Furthermore, pathologists should actively look for underlying predisposing factors such as advanced age, missing teeth, prolonged hospitalization, and psychiatric or neurological conditions, in addition to identifying the foreign body or food bolus obstructing the airway.

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