OESOPHAGOSCOPY: A MEANS OF DETECTING FOREIGN BODIES NON-OPAQUE TO X RAYS.

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THE fish bone, and often the dangerous sickle-shaped haddock bone, is one of the commonest of the various foreign bodies which become lodged or impacted in the human gullet. In such cases the information obtained from an x-ray screen examination or from a radiogram is generally unsatisfactory and may be misleading. The bismuth pastille and attempts to get some barium porridge to adhere to the foreign body have nearly always failed us.

In a certain number of cases we are convinced that a foreign body is present because of the symptoms and condition of the patient, but we are not sure where it is, though I admit that in this group the average patient locates the level fairly accurately. In another, perhaps

more important, group of cases there exists a doubt, not only on the part of the surgeon but on that of the patient, as to whether a foreign body is present or not; an x-ray examination and radiogram turns out (in the case of a fish bone) to be negative, and the patient may be allowed to go without anything further being done. A certain proportion of these people actually have an impacted bone in the gullet, and one of three

FIG. 1.—Radiogram showing shadow of bariumized wool mass enveloping fish bone in upper portion of gullet.

things may occur: (1) the bone may become loosened and pass into the stomach; (2) the patient may vomit the bone; (3) peri-oesophageal abscess, septic mediastinal infection, or haemorrhage from erosion of one of the large blood vessels, and death. Again, in the case of a "suspected" fish bone in the gullet, oesophagoscopy, without any definite information as to the level of the bone, may be negative, and the "intruder" may be vomited soon afterwards (if the patient is thus fortunate) owing to the manipulation of the tube causing disimpaction.

The above examples are a few of the snags which occur every now and then to the experienced oesophagoscopist; they will necessarily occur much more frequently in the hands of one who is not so experienced.

Any reliable information, therefore, obtainable before passing the tube, and, in addition, something which will arrest the eye at the level of the foreign body during the passing of the tube, will assuredly help to lessen the difficulties and dangers that sometimes crop up in such cases. Both of these desirable aims are attainable by the following simple method.

Small pieces of cotton-wool are lightly teased out to the size of a shilling or slightly larger and soaked in barium porridge, and are given to the patient to swallow one at a time to the number of six to eight pieces. A minute or so afterwards a teaspoonful or more of barium porridge is swallowed. Two or three minutes are then allowed to elapse to give any surplus barium time to leave the gullet.

This, of course, should all be carried out in the x-ray room. The gullet is then radiographed. The radiogram (Fig. 1) needs no description except to note that the shadow of the wool mass held up round about the foreign body is invariably of inverted "cone" shape. On passing the oesophagoscope, the lustrous white reflex from the upper part of the bariumized wool immediately arrests the eye. In every one of the cases of large haddock bone the latter has been found closely invested by the wool, like a chrysalis in its cocoon. Figure 2 shows this quite clearly.

In some of the cases the bone was recovered together with the main mass of wool after several small pieces of wool had been removed from its upper end. In other instances, where the bone was firmly impacted in the gullet wall, the wool required removal piecemeal until the exact site of impaction was recognized and disimpaction carried out.

In all of the cases in which this method has been employed so far the site of impaction was the upper part of the gullet, as it usually is in this variety of foreign body. With the exception of one case, that of a stockily built man with a short "bull" neck, oesophagoscopy was performed under local anaesthesia in conjunction with a hypodermic injection of morphine and atropine given three-quarters of an hour or so before.

The last case of the series was that of a man who stated that he had swallowed a meat bone, which he thought had "stuck" in his throat. Radiography without the bariumized wool was negative on two occasions; on the third, with bariumized wool, it was positive. On recovering the meat bone the reason for the negative result was discovered, the bone being an extremely thin transparent disc about the size of a two-shilling piece.

In conclusion, it is perhaps as well to note that a contra-indication to the use of this method would be any degree of dyspnoea in association with a foreign body suggesting involvement of the larynx.

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FIG. 2.—Photograph of a fish bone enmeshed in the bariumized wool after removal from gullet.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE SEPARATION OF THE PLACENTA.

For some time it has seemed to me that to ligature the maternal end of the umbilical cord after the birth of the child is a useless and in many cases a harmful procedure.

My attention was first called to this point when performing Caesarean section, when the object was (after the extraction of the child) to get the uterus as fully contracted as possible before introducing sutures. I noticed then that by leaving the maternal end of the cord untied, so that it could bleed freely, the placenta was more easily removed and the cut uterus contracted more rapidly and firmly and consequently needed fewer stitches.

Then again, after delivery in septic cases, such as often occur in Kashmir, where hollyhock root, cow dung, fowl intestine, and quince seeds are found in the vaginae of women treated by the native midwife, and where the cord when cut sometimes exudes a yellowish juice suggestive of faecal matter, it seemed a distinct advantage to