IMPACTION OF SWALLOWED FOREIGN BODIES.

BY

HORACE MATHER, M.R.C.S., L.R.C.P.,

HONORARY OPHTHALMIC SURGEON, EYE AND EAR INFIRMARY, LIVERPOOL.

THE two following cases seem worthy of record on account of the remarkable history in each case.

CASE I.

On December 19th, 1928, a mother brought to hospital her baby, aged 3 weeks, saying that she thought the infant might have swallowed a safety-pin. On being questioned she stated that the day previously, while she was undressing the baby, which was on her knee, she dropped a safety-pin out of her own mouth, and failed to find it either in her own or the child's clothing. Suspecting that it had been swallowed she gave the baby a dose of castor oil, "to make sure," and put it to bed.

When seen, the baby appeared to be perfectly fit, but the resident decided to x-ray the child, and there was the open safety-pin, lodged in the oesophagus, with the point upwards, at the level of the manubrium sterni.

A few hours later I passed the smallest oesophageal tube that I had, under general anaesthesia, freed the impacted point of the safety-pin with Brüning's forceps, and removed it quite easily. It proved to be one of the gilt variety, measuring three-quarters of an inch from tip to bottom of hinge. The baby was perfectly fit, and was discharged a few days later.

In view of the extraordinary (in fact incredible) nature of the history, I interviewed the mother a week later, and questioned her. I felt convinced that I should elicit from her the fact that the pin had been sucked down by the baby, either from the mother's lips or fingers. I felt that no baby would swallow such an object, if dropped into its mouth when crying or yawning, for when feeding its mouth is practically closed. Also, why the dose of castor oil, unless the mother knew that the pin had gone down? However, I failed to shake her story, and was ultimately forced to believe her.

The second case was even more remarkable.

CASE II.

A man, aged 44, a factory worker, was admitted to hospital on December 31st, 1928; he was said to be suffering from tonsillitis.

He was treated for some days, and a note was made that his appetite was fair. He complained of a little pain in the throat and some difficulty in swallowing. He admitted that he could drink fluids, and on January 4th he ate bread-and-butter easily.

On January 9th he was sent to me with a request to look at his larynx. On doing so I saw a normal larynx, but above it a linear object. I asked him what he had been swallowing, and he denied that he had swallowed anything at all. I told him he had something there, and forthwith digitally removed a large bone (see illustration). The patient was as surprised as I was.

On going into the history I ascertained that on December 22nd (a Saturday night) he had had some soup, and felt abdominal pain after it. He was disinclined for food, and on Boxing Day he tried to vomit, and felt a sharp pain in his throat. I taxed him with being drunk on December 22nd, but he strenuously denied it, although he admitted that on that day, and on December 26th, he had had four pints of beer at most.

The bone measured $2\frac{1}{4}$ by 1 inch, and varied in thickness from $1\frac{1}{4}$ to $1\frac{1}{24}$ inch. It was wedge-shaped, and had been cut with a butcher's saw. It lay transversely in the pharynx, with the narrow edge upwards, impacted by its two "points," behind the epiglottis, and its thin edge lying upwards. It could only be seen from the mouth by means of a mirror.

My explanation of the case is that, in spite of his denial, he was drunk on December 22nd and swallowed the bone in the soup, and it went down sideways and lodged in the

oesophagus, probably at the cardiac end. It was vomited up on December 26th, and lodged in the pharynx in its long axis. Being too drunk to know that it had gone down, he never suspected its presence when it returned. Consequently, neither he nor anyone else looked for it, and it was only by accident that I found it. Certainly it is remarkable that it should have been there for eighteen days.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

GRANULOMA INGUINALE RESEMBLING A
PRIMARY CHANCRE.

THE following case is of interest since it shows how a disease rarely seen in this country may simulate and be mistaken for a common one.

A ship's steward, aged 30, developed a small papule on the glans four days after exposure to venereal infection in Brazil. This rapidly became an ulcer of about the size of a sixpence. After this ulcer had been present about six weeks the patient returned to England, where, in spite of a negative Wassermann reaction and failure to find spirochaemes in the sore, a course of antisyphilitic treatment was commenced. Eight intravenous injections of neokharsivan (total 4.5 grams) and eight intramuscular injections of bismuth metal (total 1.6 grams) had been given before the patient was seen by me.

The ulcer was still present, and apparently in its original condition, since it conformed with the original description: "punched-out, undermined edges, bleeds easily." The base of the ulcer was covered with healthy-looking granulations, scrapings from which contained numerous mononuclear leucocytes and also many bacilli showing bipolar characters with Leishman's stain. Many mononuclears were packed with these bacilli. There was apparently at no time any marked inguinal adenitis.

Treatment with antimony by the intravenous route was decided on. After the first injection of 0.3 gram of stibosan (von Heyden 471) the ulcer began to heal, and after five injections (total 1.5 grams), given on alternate days, the ulcer was completely epithelialized.

This case I believe to be one of granuloma inguinale in its early stage. The lesion was of small size, and the typical spreading condition involving the scrotum and inguinal regions, which, as Manson-Bahr points out, may take years to develop, was not present. The diagnosis, therefore, was not easy on clinical grounds, but is supported by the following points:

1. It was contracted in Brazil.
2. It was of three months' duration, and hence unlikely to be a chancre.
3. It showed no response to antisyphilitic treatment.
4. Scrapings showed intracellular bipolar bacilli.
5. The Wassermann reaction was negative six weeks after the sore first appeared and before any antisyphilitic treatment was given.
6. It healed rapidly on treatment with antimony.

It is important to remember the possibility of such a condition amongst seamen presenting themselves for treatment after arrival from foreign ports.

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C. ALLAN BIRCH, M.D., M.M.S.A.

Royal Infirmary, Liverpool.

THE PLANTAR RESPONSE IN HYPOGLYCAEMIA.

IN view of Dr. D'Arcy Hart and Dr. Hilda Bond's article (May 18th, p. 895), the following case-history may be found of interest, bearing out as it does their finding that in hypoglycaemia the plantar response becomes extensor.

The patient, aged 21, was found, on admission to the Royal Chest Hospital, on June 8th, to be suffering from severe diabetes, his urine being loaded with sugar and acetone bodies, of which latter his breath smelled strongly. Treatment with insulin was therefore started at once, combined with a diet of 25 calories per kilo on Lawrence's line ration scheme. The insulin had to be increased till, on June 15th, he received no less than 120 units; but as he was sugar-free, the next day the dose was reduced to 80 units. Sugar reappeared in the evening, so on June 17th he was given 40 units before breakfast and 40 before lunch.