The authors have written consent to use figure 1 for education and publication.

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IMAGES IN EMERGENCY MEDICINE

An unusual presentation of foreign-body ingestion at the emergency department

Figure 1 Direct x ray showing several foreign bodies in the stomach and subdiaphragmatic free gas.

A 30-year-old man presented to the emergency department with exhaustion, weight loss and abdominal pain. He had been having pain in the stomach, nausea and vomiting for the previous 2 days. The patient had received psychiatric treatment and treatment for alcoholism for the previous 3-4 years, and started to experience weight loss and exhaustion 3-4 months previously. No conclusions could be drawn from physical examination for abdominal tenderness and defence. Direct x ray showed an appearance conforming to a large number of foreign bodies in the stomach and subdiaphragmatic free gas (fig 1). The patient was sent for emergency surgery, with a diagnosis of gastric perforation and foreign-body ingestion.

Most of the ingested foreign bodies that reach the stomach pass through the alimentary tract without complication. Perforation occurs in <1% of all cases of foreign-body ingestion, usually in the oesophagus. Other sites where perforation can occur are the pylorus, the duodenum, the duodenojejunal flexure, the ileocaecal region and any site of congenital anomalies.¹ Long, thin or sharp objects, as seen in our case as well as in those causing gastric perforation, are less likely to negotiate the pylorus or duodenum.² Foreign-body ingestion is a possibility to be borne in mind at presentations to the emergency department, especially those with symptoms described in psychiatric cases.

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Emergency casebook

Please visit the *Emergency Medicine Journal* website (<http://emj.bmj.com/>) for links to the full text of these emergency casebooks.

Bradycardia in minor trauma: don't be slow on the uptake! ►

We report the case of a 13-year-old boy presenting with profound bradycardia following minor trauma. Our patient had gastroschisis at birth and has moderate learning difficulties

but is otherwise fit and well. Whilst playing at home he fell sustaining a minor cervical hyperextension injury. He immediately complained of tetraplegia and hyposensitivity. The ambulance crew noted profound bradycardia with normotension and he was transported to hospital with full spinal immobilisation precautions. Over the subsequent 2 h he made a full neurological recovery. Bradycardia persisted with a beat-to-beat variation of 30-60bpm. ECG showed sinus bradycardia with atrial ectopics and he remained haemodynamically normal. Neuroimaging studies revealed hypoplasia of the odontoid peg with a relative narrowing of the spinal canal at this level. There was no evidence of spinal cord contusion or compression. His bradycardia resolved over 36 h without further intervention. On discharge the