paper and re-assure him that permission to utilise parotidectomies performed by the maxillofacial department was sought at a joint ENT/maxillofacial audit meeting. Two consultant maxillofacial surgeons representing the department were present, both were supportive of the proposed study and neither raised any objections. We would also like to emphasise the excellent co-operation and communication that exists between the two surgical departments at the Luton and Dunstable Hospital, highlighted by joint monthly audit meetings and weekly head and neck MDT meetings. We appreciate Mr Majumdar's constructive criticism and will consider his contribution should a repeat prospective study be conducted.

Complication of oesophagoscopy and anticoagulation

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Most reported injuries of the oesophagus are due to endotracheal intubation or oesophagoscopy.¹ Procedures that involve intubation of the pharynx are commonly performed and currently anticoagulation is not thought to be a contra-indication. We highlight a case that may have been prevented, if anticoagulation had been stopped prior to the procedure.

A 58-year-old man attended for an elective transoesophageal echocardiogram (TOE). Transthoracic echocardiography had previously been unrewarding due to large body habitus. The patient was anticoagulated with warfarin (chronic AF) and had a persistent cough. Coughing during oesophageal intubation forced the examination to be abandoned. On waking, the patient described pain in the left anterior neck. ENT identified a tender swelling in the left neck, left submucosal supra-glottic swelling and dysphonia. A CT scan showed surgical emphysema and a 4-cm haematoma. His INR was 1.5 and warfarin was stopped, but not reversed. He was transferred to the ENT unit, where he was managed with steroids, antibiotics and fluids. His symptoms and signs resolved after several days and he was discharged uneventfully.

Injuries to the pharynx and oesophagus may have life-threatening sequelae. In recent history, TOE is performed in anticoagulated patients during cardiac valve replacements, which may be more commonly seen in the future in an ageing population. This case raises interesting questions such as should anti-coagulated patients undergoing oesophagoscopy have their anticoagulation reversed (when medically safe)?² Further, should we

have a higher threshold for surgical intervention given the uncomplicated resolution of symptoms in this patient?

Procedures involving pharyngeal intubation may be traumatic with potentially severe consequences but may be managed conservatively on occasion.

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Splenic injury following colonoscopy

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COMMENT ON

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I agree with the authors that splenic injury following colonoscopy has been under-reported and is likely to increase with an on-going National Bowel Screening Programme.

In this particular case, re-anticoagulation with warfarin seems to be one of the predisposing factors causing secondary bleed. The spleen was found to be shattered with very little enhancing tissue on the computed tomography scan highlighting that injury was due to traction injury to the atheromatous splenic vessels rather than the capsular tear as seen in our case report.¹ Although possible mechanisms of injury have been postulated in this case report and previous publications,¹ the type of injury to the spleen (capsular or vessel) will help delineate the exact mode of injury to the spleen.

It leaves the dilemma of whether splenic trauma should be mentioned on the consent form as a complication of colonoscopy. The true incidence remains unknown as authors have high-lighted that it may remain undiagnosed or be misdiagnosed as post-colonoscopy discomfort.

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