OESOPHAGEAL FOREIGN BODY IN FOUR MONTH OLD INFANT

S. P. S. Yadav¹, Asruddin², Rohtas K. Yadav³, Jagat Singh⁴, Geeta Gathwala⁵

ABSTRACT : *A 4 month old male infant was brought with only strong suspicion of foreign body ingestion without any symptomatology. X-ray examination revealed foreign body at cricopharyngeus, which was managed successfully emphasizing the fact that a strong suspicion and relevant radiography is the key to early and successful management.*

The diagnosis and management of foreign bodies in the air and food passages ordinarily poses a problem due to late diagnosis and mismanagement, unless there is a clear-cut positive history of foreign bodies inhalation/ingestion and is handled by a skilled endoscopist. Common problems are parental ignorance or negligence with absence of positive history of foreign bodies. The problem is sometimes created because of absence of positive roentgenogram finding or inadequate roentgenographic studies. Errors created by inexperienced consultants in diagnosis and inappropriate use of instruments are the other causes of complication in these cases.

A 4 month old male infant with no definite history and no positive symptoms but a strong suspicion by parents for foreign body ingestion is being reported here.

CASE REPORT

A 4 month old male infant was brought within hours after

strong suspicion of foreign body ingestion to ENT Dept. of PGIMS, Rohtak. Child was lying on bed with his 5 year old sister who was playing with him and she suddenly noticed that her one ear top/ring was missing. It was searched on the bed where they were playing. Suddenly parent got suspicious and thought that child has ingested it accidentally because child had touched her ear once. There was no history of feeding difficulty, vomiting, cough or excessive crying. X-ray chest including neck was done, foreign body was present at cricopharyngeus (Fig. 1).

Hypopharyngoscopy was done without any anaesthesia. Since such a small size hypopharyngoscope was not available, only a glimpse of the foreign body was obtained which was accidentally pushed down as the child moved. Repeat radiography revealed the foreign body in stomach and was allowed to come out naturally which was expelled within 24 hours in stools. Patient was discharged next day, no complication was noticed.

DISCUSSION

Jackson¹ reviewed 3000 cases of foreign bodies and listed carelessness as the primary cause of these ingestions or inhalations in 87% of the patients.

Child may present with acute symptoms of coughing, choking, excessive salivation, dysphagia or vomiting.² If foreign body remains impacted, adaptation may occur and the child will select foods which can be managed without producing symptoms.³ In some cases there is no definite history or acute symptomatology and presentation occurs in an obscure fashion i.e. chronic respiratory symptoms (stridor, wheezing, recurrent pneumonia), anorexia, haematemesis.⁴

During childhood, accidents occur when they suddenly inspire during play or fight while having something in the

Fig.1: X-ray chest including neck showing foreign body at cricopharyngeus

¹Assoc. Professor, ²Jr. Resident, ⁴Lecturer, Department of Otorhinolaryngology, ³Assoc. Professor, Radiology and ⁵Reader, Neonatology Division, Pt. B. D. Sharma, Post Graduate Institute of Medical Sciences, Rohtak – 124001, (Haryana)

mouth. In these case there will be sudden cough with choking spells. But sometimes this may not be noticed by parents and give rise to obscure symptoms of pneumonia. Negative history of foreign body ingestion/inhalation and delayed recognition of the possibility of foreign body as the cause of the presenting symptoms in children may cause complication and even deaths. Inadequate roentgenograms, particularly not including the neck in chest x-ray and inappropriate use of endoscope may all lead to complication.⁵

Although it is not uncommon to find foreign bodies in aerodigestive tracts in children but these are very rare in young infants as in this case, however, we have removed a foreign body oesophagus in two week old infants in whom the foreign body an iron scrap was put in the mouth of the neonate by 3 year elder sibling giving an evidence of sibling rivalry even in very young children.⁶

REFERENCES

1. Jackson C. (1979) : Foreign bodies in air and food passage. In:

English GM, ed. Otolaryngology. Hagerstown: Harper & Row, 1 – 94.

2. Nandi P, Ong GB. (1978) : Foreign body in the oesophagus : review of 2394 cases. Br J Surg 65: 5 – 9.
3. Glordano A, Adams G, Bories L, Meyerhoof W, (1981) : Current management of esophageal foreign bodies. Arch otolaryngol 107: 249 – 51.
4. Goldsher M, Eliachar I, Joachims HZ. (1978) : Paradoxical presentation in children of foreign bodies in trachea and oesophagus. Practitioner, 220: 631 – 32.
5. Choen SR.(1981) : Unusual presentation and problems created by mismanagement of foreign body in the aerodigestive tract of the patient. Ann Otol 90: 316 – 22.
6. Singh I, Gathwala G, Yadav SPS, Sharma A. foreign body oesophagus in a neonate. Ind J paed (in press).

Address for Correspondence :

Dr. S. P. S. Yadav
30/9 J, Medical Enclave
Rohtak – 124001
Haryana (India).

UNCOMMON COMPLICATION OF QUINSY

G. Laxmipathi¹, Nagendra Mahendra², Vijay Kumar³

ABSTRACT : *A rare case of "quinsy with uncommon complication" and its management with review of literature is reported. Quinsy as a complication of acute or chronic Tonsillitis and Dental Infection is still seen at regular frequency inspite of modern antibiotics. This case inspite of having an early and proper incision and drainage ended up having retro and para-pharyngeal abscess which tracked down leading to Mediastinitis and Empyema Chest. Early Inter-Costal drainage prevented fatality and helped in rapid recovery.*

Quinsy is a Latin word and Quinancia in medieval English described any throat infection. In Anglo-Saxon literature Quinsy is the term for peritonsillitis/abscess. Cynanche is a Greek word used to describe any inflammation of throat and neck. (cyn: dog. anchien : throttle). But Hippocrates reserved the word for those cases which were complicated by difficulty in swallowing (Brandon 1977). According to Bonding (1973) and Johnsen (1981) it is a relatively frequent complication of tonsillitis & infectious mononucleosis. Quinsy is more common in adults but not very rare in children (Grahne 1958). Bilateral Quinsy is rare but reported by Brook and Shah in 1981. Flodstrom

& Hallender 1976 concluded that beta. Hemolytic streptococci & various anerobic bacteria like Bacteroides Pseudobactirium peptostreptococcus were the prominent flora. Previously Staphylococcus Aureus, Haemophilus Influenzae and Pneumococcus were the organisms thought of. The first Incision and drainage was done by a French surgeon in 1362. Controversy exists regarding management of such cases, with usual treatment being Incision and drainage followed by Tonsillectomy after 6-8 weeks in the young & regular follow-up of patients above 40 years of age. Chasaignac in 1859 first proposed Tonsillectomy a Chaud immediate/hot, but it was deferred

¹Senior Hon. Consultant, ²E.N.T. Consultant, ³Registrar, Department of E.N.T. Durga Bai Deshmukh Hospital, Andhra Mahila Sabha, Hyderabad – 500044, A.P.