

believe that the clinical data obtained from our study indicate that prophylactic antibiotic use in CND is likely to be the important factor for minimizing the risk of post-operative wound infection development. However, like others, we would welcome a future double-blind, placebo-controlled trial.

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Importance of X-ray in chronic stridor

Dear Sirs

We report the case of a 30-year-old woman who presented with a 5-week history of progressively increasing stridor, dysphagia and occasional vomiting. Two years previously, she had undergone a colonic interposition graft to bypass a corrosive induced oesophageal stricture. After the operation she had been able to eat and drink normally without any problem. Six weeks before presentation she swallowed a kitchen knife which was removed by means of an operation through a

cervical incision. Ten days later, she was transferred to a psychiatric hospital for rehabilitation and spent 3–4 weeks there. During this time she developed minimal stridor and dysphagia but was able to eat and drink. Thus the stridor was ignored by the doctors.

Three days after her discharge from the psychiatric hospital, she attended an accident and emergency department with total dysphagia and vomiting. She denied any foreign body ingestion. She was referred to an ENT team, without X-ray, because of her stridor and previous history. On examination, whilst on air, she had biphasic stridor, spitting of saliva and no cyanosis. She appeared to be comfortable with a SaO₂ of 96 per cent and a temperature of 37.4°C. Chest examination revealed transmitted stridor and slightly diminished air entry which was bilaterally symmetrical with no wheeze.

X-rays of her chest and neck (Figures 1 and 2) showed no obstruction in the trachea, visible air in the oesophagus and the rubber tip of a syringe plunger, visible at the level of T2 spine.

The patient admitted having swallowed a syringe plunger when she was in the psychiatric hospital but had not told the doctors. She told the psychiatric doctors about her mild dysphagia and difficulty in breathing which were ignored because of normal vital parameters. Once the plunger was discovered, she underwent pharyngoscopy and oesophagoscopy and the plunger in the oesophagus was removed. Post-operatively she underwent barium swallow, which revealed sluggish peristalsis and no obstruction in the colonic interposition graft. She was therefore discharged.

Foreign body ingestion is a common occurrence in children and specific high-risk groups of adults such as those with underlying oesophageal disease, prisoners, the mentally retarded, and those with psychiatric illnesses.¹ The most common foreign bodies are fish bones in adults

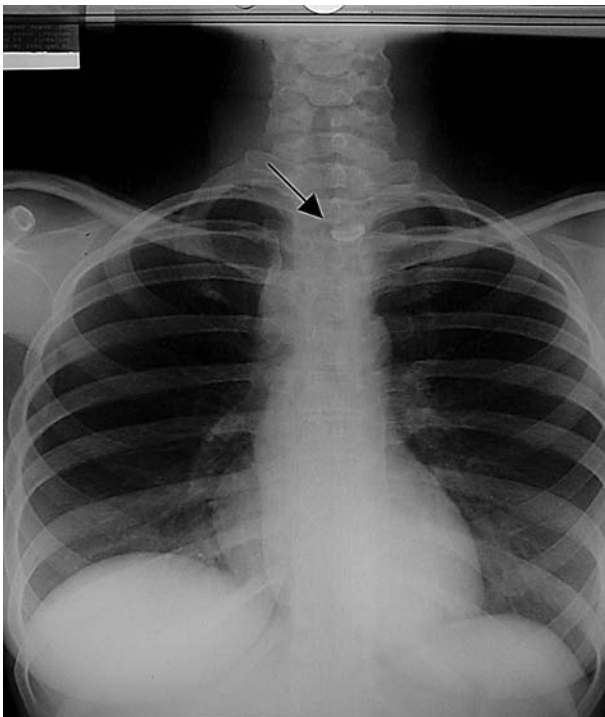


FIG.1

X-ray of chest showing the tip of a syringe plunger just above the medial end of the left clavicle.



FIG.2

X-ray of neck showing air in the trachea and oesophagus. Foreign body is not obvious.

and coins in children.^{2,3} Most of the objects are impacted at or above the cricopharyngeus, the commonest site being the valleculae.² Dysphagia, odynophagia, chest pain⁴ and foreign body sensation are the usual symptoms of a foreign body in the oesophagus. Hypersalivation is often associated with an abnormal oesophagoscopy.⁵ Respiratory symptoms can occur due to compression of the adjacent trachea. Children can be inappropriately treated as having upper respiratory infections.⁶ Clinical suspicion is very important in diagnosing a foreign body in the oesophagus. Plain X-ray, barium swallow, CT scan and endoscopy will all be useful in detecting the foreign body.

Rigid oesophagoscopy is the best method for removing all oesophageal foreign bodies.^{1,7,8} Selected foreign bodies can be removed using a Foley balloon catheter under fluoroscopic control without anaesthesia.⁸ Non-endoscopic methods of removal are associated with increased risks. The success rate of foreign body removal is as high as 98 per cent, with minimal or no complications. Even though this patient recovered from her initial operation, she later developed a stridor suggesting another foreign body which was ignored. Because of her prior colonic graft she was able to eat for 4 weeks. Her stridor was due to extraneous compression on the tracheobronchial tree due to the foreign body in the oesophagus. The plunger was visible in antero-posterior (AP) view, suggesting that both AP and lateral views should be viewed. Any patient with a colonic bypass graft who presents with a stridor and dysphagia should be examined for foreign body ingestion and should always be X-rayed.

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