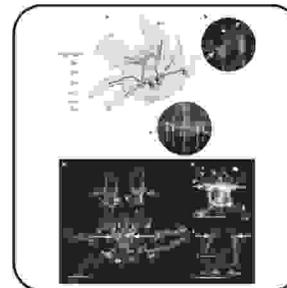


CASE REPORT

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IMPACTION OF A SEED IN THE OESOPHAGUS; PROLONGED DYSPHAGIA & VOMITING FOR 3.5 (THREE & HALF YEARS) IN A 5 YEARS OLD CHILD - A DIAGNOSTIC CHALLENGE



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ABSTRACT... drnaeem_ent@yahoo.com. Dysphagia in children due to ingestion of foreign body is quite common. We report a case of dysphagia & vomiting in a 5 years old boy who presented in ENT OPD Allied Hospital Faisalabad. Our case is an unusual one with respect to the duration of symptoms which last for 3,1/2 years. The case was misdiagnosed as a case of stricture of oesophagus on a number of occasions. The foreign body seed was removed per orally with the help of rigid Oesophagoscope. Literature review has been done and discussed.

Key words: Foreign body, Dysphagia, Rigid Oesophagoscopy.

INTRODUCTION

Dysphagia in children due to ingestion of foreign body is quite a common condition. Over 90% of ingested foreign bodies pass uneventfully through the gastrointestinal tract. If the foreign body fails to pass through then it is commonly impacted in the oesophagus¹. 80% of the impacted foreign bodies are held up at the level of cricopharyngeus². In the majority of cases there will be a clear history of ingestion of foreign body. The child will present with acute symptoms of coughing, choking, excessive salivation, dysphagia or vomiting^{3,4}. Diagnosis is confirmed by plain x-rays of neck and chest, both PA and lateral views provided the ingested foreign body is radio-opaque. The endoscopic examination not only confirms the diagnosis but also helps in its removal. A

rare case of prolonged dysphagia and vomiting in a 5 years old boy has been presented.

CASE REPORT

A 5 years old boy presented with history of prolonged dysphagia and vomiting for 3, ½ years. The patients parents did not give any history regarding ingestion of foreign object, corrosive intake, trauma or any surgical intervention. However, his parents gave history of hospitalization and treatment at different tertiary care hospitals in Punjab on different occasions. In one hospital his tonsillectomy was done. In another hospital, he was diagnosed as having a stricture at 22 cm of the oesophagus. At the time of admission, he was very weak and his hemoglobin was 7.6 grams/dl. He was transfused

3 pints of blood. His x-rays barium swallow had already been performed in 2004 which revealed a sort of stricture in the lower part of the oesophagus. Any how, the boy was scoped under general anaesthesia. At 22 cm of the oesophagus, a sort of granulation tissue was noted. This so called granulation tissue was removed and checked. It was found to be a small piece of organic material resembling the outer covering of a seed. The whole of the organic material was removed piece meal and checked. It was found to be the "Seed of Imli". The rest of the oesophagus was examined for any stricture or narrowing but no pathology was identified. During oesophagoscopy, no complication occurred except slight ulceration and mild bleeding. Nasogastric tube was passed and a check x-ray of chest was done. No complication was noted in 1st 48 hours of the post operative period. His feeding was started first through N-G tube and later on orally and the N-G tube was removed. The patients symptoms of dysphagia and vomiting cleared after surgery.

DISCUSSION

Foreign body ingestion is quite common in paediatric gastrointestinal practice⁵. A variety of foreign bodies have been described in the literature like coins, pins, needles, hair, denture, seeds, battery cells, fish bone etc. These are the usually encountered foreign bodies and constitute about 80% of total foreign bodies⁶. There are four sites of anatomical narrowing in the oesophagus where foreign bodies are likely to impact. These are postcricoid region, the level of arch of aorta, the level of left main bronchus and the level of the diaphragmatic hiatus⁷. 80% of the impacted foreign bodies are held up at the level of cricopharynx². Impaction may also occur at sites of pathological narrowing e.g, congenital stenosis, corrosive stricture, anastomotic strictures or strictures secondary to peptic oesophagitis. In majority of the cases there will be a clear history of ingestion of a foreign body. The child will present with acute symptoms of coughing, choking, excessive salivation, dysphagia or vomiting^{3,4}. If the foreign body remains impacted, adaptation may occur and the child will select foods which can be swallowed without producing symptoms⁸. In other cases there is no definite history of acute symptomatology and presentation occurs in an obscure fashion e.g chronic

respiratory symptoms (stridor, wheezing, recurrent pneumonia)⁹. Occasionally the child presents with anorexia, haemetemesis or pyrexia of unknown origin². The diagnosis will be confirmed on plain PA and lateral x-rays of neck and chest provided the foreign body ingested is radio-opaque. Further investigations are needed in those patients in whom a foreign body is suspected but not seen on plain x-rays. These investigations include a barium oesophagogram¹⁰, CT scan of neck and chest¹¹ and endoscopy.

Rigid endoscopy has a definite role in diagnosis and removal of foreign bodies. All foreign bodies lodged in the upper 1/3 of the oesophagus as well as sharp objects in the lower oesophagus should be removed by oesophagoscopy. Rounded objects e.g marble may be dislodged by a foleys balloon catheter. Rounded objects e.g coins, in the lower half of the oesophagus may be observed for 24-48 hours because they spontaneously pass into the stomach. If ingested foreign body has passed beyond the cardia, only those patients who are symptomatic require further investigations. Searching of stools for foreign body is both unpleasant and inaccurate¹². Button batteries should be removed as soon as possible to avoid the danger of erosion through the wall of the oesophagus, e.g. the development of a tracheo-oesophageal fistula¹³. Associated strictures of the oesophagus should be dilated and subsequently subjected to further investigation and definitive treatment.

Problems usually arise in proportion to the duration of impaction of the foreign body. Possible complications due to ingested foreign bodies include ulceration, hemorrhage, stricture formation, tracheo-oesophageal fistula, erosion through the wall of the oesophagus with mediastinal abscess or penetration into major blood vessels¹⁰. Perforation may also occur during attempts at endoscopic removal of a sharp object.

Our case is unusual one with respect to the duration of symptoms which last for 3, ½ years. Rigid esophagoscopy helps a lot not only in making a diagnosis but also in complete removal of the foreign body. Therefore it is a cost effective and more accurate method for diagnosis and treatment. It must be done by

the senior most ENT consultant. Moreover it is also stressed that the surgeon should probe the cause of dysphagia. He should keep the possibility of foreign body in mind while doing endoscopy especially in children.

CONCLUSIONS

Rigid Oesophagoscopy- helps in diagnosis & also removal of foreign body. It must be done by the senior most ENT consultant. The consultant should not remain superficial. He should keep the possibility of foreign body in mind while doing endoscopy especially in case of children. If granulation tissue found during endoscopy examination it must be biopsied and, if required,-repeated.

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