Ingested Sharp Foreign Body Pin in the Oesophagus- A Clinical Case note

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Abstract

Foreign body pin in the Oesophagus usually occurs in mentally challenged people or accidentally and is a very occurrence in emergency. Rarity, technical difficulty in removing the foreign body, complications associated with the delay in diagnosis and treatment, migration of the foreign body extraluminally and site, shape and position of the sharp end makes this entity interesting and worth reporting.

We report a mentally sound adult male who had accidental ingestion of sharp foreign body pin which migrated very early extraluminally that lead to a negative oesophagoscopy, and necessitated external removal.

Keywords: Foreign body, Oesophagus

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Introduction: -

Rigid Oesophagoscopy remains a routine practice of choice for foreign body pin in oesophagus. We report an interesting case of foreign body pin in oesophagus, in which the emergency oesophagoscopy turned negative in spite that foreign body was noted on lateral and antero-posterior radiograph. This case report also stresses the necessity of quick intervention in such cases to avoid further migration of foreign body and careful

assessment using criteria and also importance of computer tomograms.

Case History: - A 37 year male patient presented to the emergency medical service of the tertiary care hospital, JIPMER, Puducherry, India with history of accidental ingestion of foreign body pin about 6-8 hours prior during the meal session. Patient complained of pain during swallowing, a relative cessation of fluid and food intake, with no voice change and no history of respiratory distress. He had no additional co-morbid histories. His oral cavity, oropharynx examination was within normal limits. His indirect larynoscopy showed pooling of saliva in the right pyriform sinus, with no further remarkable signs. The radiograph of the neck antero-posterior view revealed foreign body in the right neck at the level of C6 in the right lateral side. Soft tissue neck lateral view revealed no evidence of prevertebral widening or straightening of spine. Relatively a routine and straightforward patient for diagnosis and management, the patient was taken for emergency oesophagoscopy under general anaesthesia after pre-anaesthetic check up and consent.

Oesophagoscopy, in contrast to our pre-operative expectations revealed no evidence of any foreign body in spite of the repetition by senior faculty. Mucosa of right pyriform sinus was unremarkable and revealed no congestion or oedema. Patient was extubated from general anaesthesia and after postoperative recovery period of two hours, an emergency computer tomogram was done. CT scan revealed the foreign body, probably a pin in the neck outside the lumen at the level of C6-C7. The foreign body had migrated outside the lumen of the oesophagus within 15 hours. And the

foreign body was removed by an external approach as per the patient's request.

Discussion

Foreign body ingestion has a wide range of presentations from throat pain, dysphagia, cervical spondylodiscitis[1] and acute fulminating abscess[2] to fatal carotid rupture[3] and migration into the neck and extrusion from the skin[4]. Various techniques[5, 6] are also described for the safe removal of such sharp foreign bodies.

In our case we found that the oesphagoscopy was negative within 15 hours. Plain radiography showing foreign body at C6 level with no evidence of prevertebral widening or straightening of spine and the symptoms of dysphagia were typically pointing towards foreign body in the patient. But the oesphagoscopy was negative for foreign body and the foreign body migrated extra-luminal within a short period. In this case the factors leading to migration of the foreign body in such a short period is poorly understood. Had the CT scan been done prior to the surgery (which may not be routinely indicated practically in all cases), the patient would have avoided unnecessary General anaesthesia procedure of Esophagoscopy. This case had showed us that time factor cannot be taken as a criterion to suggest migration and a suspicion of extra-luminal foreign body should always be kept in mind in a case of negative oesophagoscopy.

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Figure: 1 Post oesophagoscopy Computed tomography of the patient (with Ryle's tube) showing extra-luminal foreign body (pin) at the level of C6-C7.