Case report

Foreign body in the esophagus (unusual age)

Introduction

A foreign body in the esophagus may be a bolus of any other object that becomes lodged within the lumen of that viscous.

The vast majority of these foreign bodies enter the esophagus via the mouth, butoccasionally one enters through a perforated wound. (1)

Most foreign bodies are swallowed accidentally and some foreign bodies are materials never intended for ingestion that are introduced intentionally by children, psychotics. Daredevil prison as professional swallow's (1,2,3).

Swallowed foreign bodies usually passed into stomach but it may be lodged in any portion of the esophagus, about 80% lodged in the upper third and the cardia is the second most common site(1,2,4).

The effect and the symptoms of foreign bodies lodged in the esophagus vary with the size, shape and physical character of it. It may cause complete, partial or no obstruction. The wall of esophagus at the site of foreign body become inflamed, edematous, or injured immediately or by pressure necrosis leading to mediastinitis (l,2,4). Dysphagia and pain are the immediat symptoms. Later ones are persistent dysphagia and pain. Sensation of something in the gull with or without fever.(l,2).

The infant and young children have the habit of putting objects in their mouths, the mother of the family can describe the nature of swallowed object and its time.

The diagnosis is done after suspicion by radiological or oesophageal endoscopic examination Simple plain X-ray to neck and chest in two views (PA and lateral) to detect radioopaqu foreign bodies like those of metallic nature or the Slightly radioopaque like bony fragments.

Water-soluble contrast media may be used to detect the radiolucent foreign bodies.

Oesophagoscopy is the most certain method of detecting the presence or absence of foreign bodies and its nature especially in negative radiological examination .The endoscopy is use for diagnosis and therapy (for removal of the foreign bodies). (1,2,3,6).

Case presentation

A male neonate of 24th days age was brought to our surgical department by his mother with continues vomiting, with suggestion of swallowing of his safety pins of his napkin .In a plain X-ray the safety pin appeared in the lower oesophagus (fig. 1). The pin was opened and the direction of the sharp end was upward. So we put the neonate under conservative treatment (IV fluid & antibiotic) till the next morning and the X-ray was repeated. The radiological finding was the same of the first one .

The neonate was taken to the operating with decision to try to remove it under general anesthesia by passing a nasogastric tube with small magnetic piece sutured to its end to pull the safety pin that trial was failed. Laparotomy was decided with gastrostomy. The safety pin was pulled from the cardia by forceps and the neonate left the hospital in the third postoperative day without complication.

Discussion

Foreign bodies in the oesophagus may pass spontaneously to the stomach or be expelled through the mouth (rare). It may impact with or without perforation of the wall(1.2.7)

Treatment consist of removing the foreign body from oesophagus by the most appropriate method as soon as possible after diagnosis its

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method as soon as possible after diagnosis its presence, location .size and its nature (5).

The method of choice for removing foreign body that have been swallowed is by oesophagoscope either rigid or flexible fiberoptic one according to the size of the foreign body and to the availability of general anesthesia &theater (rigid one remove larger objects but require general anesthesia). (1,2,8).

If the foreign body cannot be grasped by the forceps. It may be better try to push it to the stomach.

The first thing in this case is that the neonate had swallowed an opened safety pin of his napkin, the second.This safety pin was opened, its sharp end in the upper direction. Fixed in the lower third of the oesophagus with some penetration into its wall.

If we had been waited more than 24 hours the neonate might get aspirated pneumonia because of continuos vomiting or he may get mediastinitis from progress of perforation of its tip.

There was no available neonatal endoscope & overtube as the pin was opened in upward direction. So the decision was made to remove the safety pin under general anesthesia in the theater, first by short trial by magnetic piece attached to a nasogastric tube. It was failed, so Laparotomy was done with small gastrostomy and by forceps introduced through the cardia the pin was removed easily without complication.

Coclusion

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Conclusion

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