

Letters to the Editor

Button Batteries

Dear Sir,

The article by Palmer *et al.* (1994) in the October edition entitled 'Button battery in the Nose—an unusual foreign body' made interesting reading. We would like to report a case of a six-year-old child who was presented to a busy Accident and Emergency department immediately following inserting two button batteries from a musical greeting card into his ear canal. He was in no discomfort and reported no otological symptoms. The casualty officer removed one of the batteries with fine forceps but the second was not removed in view of its position against the tympanic membrane. An appointment was made in the urgent referral clinic at the Royal National Throat, Nose and Ear Hospital the following morning and Sofradex® ear drops were prescribed 'to keep the ear canal sterile.'

Overnight the child developed severe otalgia and the following day required examination under general anaesthesia to remove the battery. The deep ear canal skin was severely inflamed and the battery had 'welded' to the anterior inferior quadrant of the tympanic membrane. Examination of the battery after it's removal showed evidence of leakage with corrosion of its metallic casing. Review of the patient two weeks later fortunately showed that both the inflammation and the perforation had healed and there were no lasting damage to the auditory meatus, tympanic membrane or middle ear structures.

This case emphasizes the need to remove button battery foreign bodies wherever they are inserted as a matter of urgency and that unlike other aural foreign bodies, referral to the next available ENT clinic is not acceptable. Contact with fluids should be avoided as they result both in battery leakage and promotion of DC electrical burn injury. It is important that we educate our colleagues in Accident and Emergency medicine of the importance of early referral so that preventable complications, as illustrated in this case, can be avoided.

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Metastatic papillary thyroid carcinoma: an important differential diagnosis for aberrant thyroglossal cyst

Dear Sir,

We read with interest the recent article by O'Hanlon *et al.* (1994) describing a case of aberrant thyroglossal cyst occurring at the lateral side of the neck.

We would like to share with your readers two recent cases of metastatic papillary carcinoma of the thyroid to the cervical lymph node. One was a 30-year-old woman and the other is a 57-year-old man. Both presented with a cystic swelling at the side of the neck. Exploration showed a cystic swelling of 2 and 4 cm respectively, which were separated from the thyroid gland. They were clinically thought to be branchial cysts.

The histological appearances in both cases are very similar, with hyalinized fibrous tissue forming the cyst wall. Internally the cysts were lined by a layer of columnar cells, identical to Figure 3 in the O'Hanlon's article. Elsewhere, there were focal papillae formation with hyalinized cores lined by columnar cells with nuclear grooves and intranuclear inclusion, typical of papillary carcinoma of the thyroid. The thyroid epithelial origin was confirmed by immunohistochemical stain for thyroglobulin. In both cases there is thin rim of lymphoid tissue surrounding the cyst wall, betraying their lymph node origin.

Subsequent ultrasound study and total thyroidectomy confirmed the presence of occult papillary carcinoma of the thyroid, which were much smaller than the cystic lymph node metastases.

Papillary carcinoma of the thyroid gland has a propensity to metastasise to cervical lymph nodes, which not uncommonly show cystic change (Rosai, 1989). While genuine *de novo* aberrant thyroglossal cyst may exist, the alternative diagnosis of metastatic papillary carcinoma from the thyroid gland needs to be vigorously excluded by adequate sampling and thorough microscopic examination.

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References

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Rosai, J. (1989) Ackerman's Surgical Pathology, 7th Edition, vol. 1, C. V. Mosby, St Louis, pp 407–416.