Letters to the Editor

Use of the flexible oesophagoscope for the removal of an intramural oesophageal foreign body

Dear Sir,

The case report by Mr V. H. Harihar, January 1991, Vol. 105, pp. 46-47 attracted our attention and prompted us to report our observation using the flexible oesophagoscope for removing intramural oesophageal foreign bodies in the pharynx and upper oesophagus. It allows confirmation of the radiographic site and position.

Fig. 1

Fig. 2

Fig. 3
of the foreign body (bony or metallic), which has been stuck for some time and become covered by fibrinous membrane which masks its viewing through the rigid oesophagoscope. Because of its small calibre it allows a wide angle of view when the oesophagus is inflated.

Case report
A 30-year-old man presented with a history of eating a piece of chicken from the grill, followed by a pricking sensation on swallowing, at the root of the neck of three days duration.

A soft tissue radiograph of the neck showed a linear shadow opposite C7 (Fig. 1); on rigid oesophagoscopy down to the gastro-oesophageal junction there was no sign of a foreign body or wound in the entire oesophageal lumen. By using the flexible oesophagoscope and after the inflating the lumen causing stretching of the wall of the oesophagus, the foreign body appeared shining under the mucosa at 25 cm with 3 mm of its end shown piercing through the mucosa (Fig. 2). The end was grabbed with biopsy forceps and recovered (Fig. 3); it was a piece of fine wire of 2.5 cm long. (Fig. 4).

Yours faithfully,  
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Reply:  
Sir,  
I read with interest of Dr Mehdi Salih's experience with flexible endoscopy for the removal of a foreign body, and thank him for sharing this with us.

All the ENT units I have been associated with have not been in favour of doing a flexible fiberoptic oesophagoscope as over the years, otolaryngologists have felt happier with the rigid 'scope. Personally would be concerned about the possibility of a through-and-through perforation of the oesophagus by the foreign body, which could result in mediastinal emphysema if air was insufflated into the oesophagus while doing an oesophagoscope.

Since my experience with this is very limited, I do not know how often this complication arises in practice. We look forward to trying this when we get the right circumstances.

Yours faithfully,  
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References

Reply
Dear Sir,  
In reply to Mr Murty's comments on our paper, it is interesting to know that familial occurrence is not quite as rare as it seems. We are glad that he concurs with our finding of lack of association of the HLA system with Wegener's granulomatosis, and await the results of the trial he mentions with interest.

Yours faithfully,  
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