AN UNUSUAL CASE OF IMPACTED OESOPHAGEAL FOREIGN BODY

Bachi T. Hathiram1, A. K Gvalani2, Nilam Sathe3, Kaushal Sheth4, Alok Mohorikar5, D. S. Grewal6

ABSTRACT: Impacted sharp foreign bodies in the oesophagus can be very difficult to manage. When attempts are made to remove such objects inappropriately, life-threatening complications such as oesophageal perforation can occur. We have reported a rare case of impacted denture in the oesophagus where endoscopic removal was not possible due to the perforation already caused by the denture, since this would have caused an oesophageal laceration, which could have proved fatal. Hence surgical removal had to be performed with repair of the oesophageal perforation.

Key Words: Foreign Body, Oesophagus, Impacted

INTRODUCTION
Ingested foreign bodies may pass through the gastrointestinal tract without sequel or may lodge in a segment of the gut. The outcome of such an event depends chiefly on the nature of the ingested foreign body - smooth foreign bodies may pass uneventfully whereas those with sharp edges may get embedded in the walls of or even penetrate the gastrointestinal tract.

Foreign bodies in the oesophagus if left unremoved, eventually prove fatal. Although in literature, an occasional patient has survived impacted foreign body in the oesophagus for up to 15 years (Jackson C, and Jackson C.C., 1950 & Turner G.G., 1947), few patients survive more than 12 months (Thorek P., 1953). Death is usually due to migration of the impacted foreign body and is preceded by considerable morbidity.

Endoscopic removal is definitely an attractive option as compared to an open surgery, however, the surgeon has to weigh the risks of endoscopic removal with the advantages of open surgery and take a decision accordingly. It is universally accepted that an impacted foreign body must be removed at the earliest opportunity.

CASE REPORT
A 56 yr old male patient came to our Out Patient Department with a history of accidental ingestion of his dentures while in his sleep the previous night. He complained of severe pain in the region of the neck with an inability to swallow liquids as well as solids since then. There was no history of dyspnoea or chest pain. However, there was excessive salivation and severe pain on attempting to swallow saliva.

On examination, there was excessive salivation with pooling of saliva seen on indirect laryngoscopy in both the pyriform fossae. Also, palpation of the neck revealed tenderness in the lower region especially on the left side in the region of the tracheo-oesophageal groove. All hematological investigations were normal. X-Ray of the neck - anteroposterior and lateral views confirmed the presence of metal wires in the lower portion of the cervical oesophagus at the level of C7 cervical vertebra (Fig I).

An emergency rigid oesophagoscopcopy was performed under general anesthesia. A denture with a tooth and its metal wires was seen lying across the lumen of the oesophagus. The metal wire was impacted in the left wall

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1Associate Professor, 2Professor and Head of Unit, Department of General Surgery, 3Lecturer, 4Chief Resident, 5Senior Resident, 6Professor and Head of Department, Department of E.N.T, T. N. Medical College & B.Y.L. Nair Ch. Hospital. Mumbai Central, Mumbai 400 008, Maharashtra, India.
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among the rural population so also is the problem of swallowed and impacted dentures. Most dentures are radiolucent and this makes radiological localization almost impossible. Also, because of their rigidity, large size, irregular edges and wires, impacted dentures are more prone to produce lacerations during endoscopic removal from the oesophagus, which is already rendered friable by impaction.

In our patient, the denture was easily localized on radiology due to the presence of its wires. Endoscopic removal was attempted only once and with all necessary precaution. However, it was clearly visible that the wires had penetrated through the wall of the oesophagus, which was very friable and bled on touch. Hence, endoscopic removal was abandoned in favor of an open approach.

The long-term use of dentures results in decreased sensation of the palate as well as gradual atrophy of the alveolus. These changes result in increased possibility of ingesting the denture. Also, old individuals have decreased sensation in the mucosa and most persons using dentures are in a habit of feeling them with their tongue, these tongue movements further increase the risk of ingestion of the dentures especially in sleep.

CONCLUSION

Oesophagoscopic removal of an impacted denture would be at the least a blind procedure and therefore risky. While endoscopic removal of an oesophageal foreign body is often possible, the method should only be employed in dealing with impacted dentures. Because of the risk of oesophageal laceration, the safest approach to swallowed and impacted dentures is by elective oesophagotomy.

REFERENCES


Address for Correspondence
Dr. Bachi T. Hathiram
Associate Professor,
Dept. of ENT, No.-28, 1st Floor, College Bldg.,
T. N. Medical College & B. Y. L. Nair Ch. Hospital,
Mumbai – Central, Mumbai 400 008, Maharashtra, India.