Failure to thrive

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Introduction

A foreign body impacted in the oesophagus is a rare cause of failure to thrive in infancy. It is sometimes lethal, a fact that is reported more often in the lay than in the Medical press. A foreign body in the oesophagus is the commonest cause of dysphagia. In five years from 1953 to 1957, at the Royal National Throat, Nose and Ear Hospital, London, out of 1,057 oesophagoscopies no less than 445 (nearly half) were for foreign bodies (Asherson, 1962).

The commonest site for impaction is at, or just below, the cricopharyngeus and 75 per cent of foreign bodies are found at this level. Most of the remainder, in roughly equal proportion, are arrested at the level of the left bronchus (mid-oesophagus) and at the cardia.

The accident is commonest in children, who are apt to place coins, pins and plastic or metallic toys in their mouths and swallow them (Flavell, 1970).

Usually the patient gives a history of swallowing a foreign body. However, this may not be so in the infirm, the insane, the inebriated, the inarticulate and in infancy.

Case history

A 1-year-old baby boy was admitted under the care of the General Physician at the Children's Hospital, Temple Street, on 22 January 1974.

A history was furnished by his father

Persistent 'wet cough' for three months, more severe at night and resulting in some episodes of nocturnal dyspnoea. There was vomiting of solid foods and now he tolerated milky foods only. The family physician had treated the child with antibiotics for chest infections but was not happy with the result. In view of this and the weight loss—7 lbs. over three months—it was decided that hospitalization was necessary.

Maternal history

Full term normal delivery. Birth weight 10 lbs. Bottle fed.

Family history

The patient was the youngest of four healthy children. B.C.G. and 'triple' vaccinations had been administered.

Clinical examination

The baby looked generally quite well but was under weight and showed moderate anaemia. There was no drooling of saliva. The baby had a cough, worse at night.

https://doi.org/10.1017/S0022215100082852 Published online by Cambridge University Press

Chest examination

Occasional rhonci throughout the left lung field. Otherwise clinical examination was negative.

Investigations

Haemoglobin 10. 1. grams per cent.
W.B.C. 12,000.
M.S.U. Normal.
Stools for ova and parasites: nil.

Chest X-ray (Fig. 1)

Large 'butterfly' nut in mid-oesophagus, displacing the trachea to the right and compressing the left main bronchus. The left lung is somewhat over distended. An E.N.T. opinion was sought.

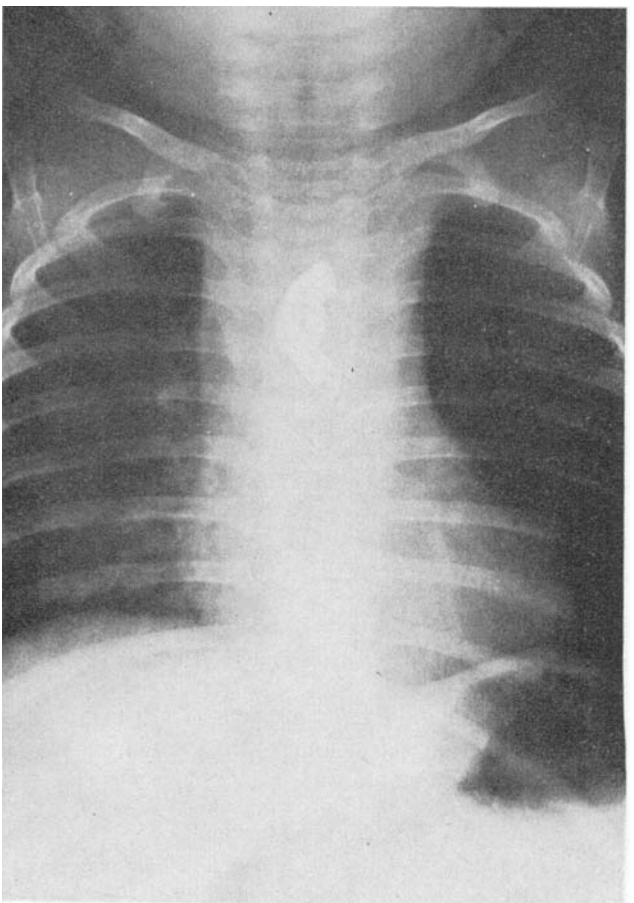


FIG. 1.

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Procedure

This was a very large foreign body (Fig. 2), however, it was decided to attempt removal endoscopically. Oesophagoscopy was performed under general anaesthesia and intubation on 24 January 1974. A large nut was removed from the mid-oesophagus with the aid of an 'alligator' forceps. The oesophagus was inflamed and oedematous.

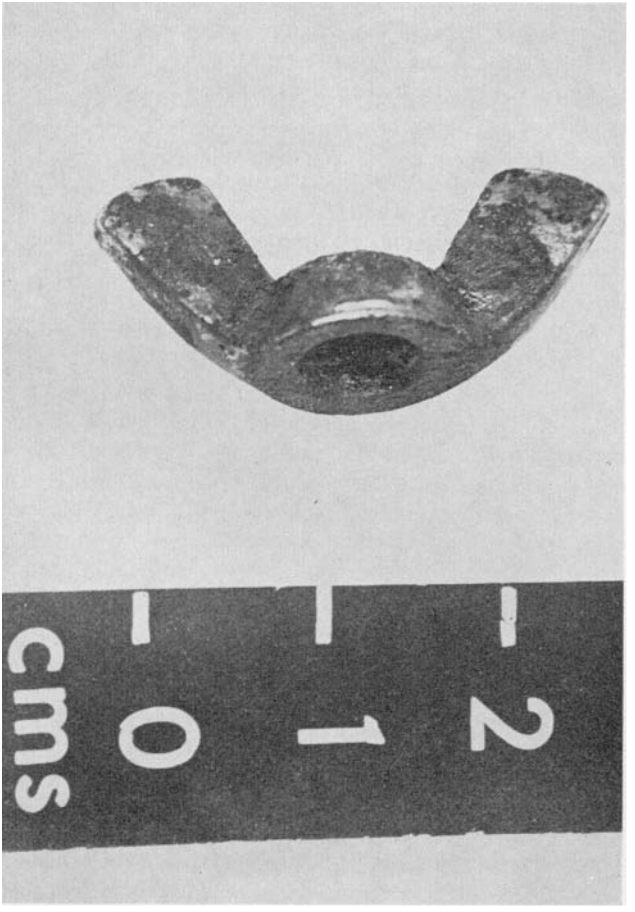


FIG. 2.

Post-operatively

The patient was treated with antibiotics and oral iron. Symptoms ceased and the baby started to feed normally. Chest X-ray post-operatively was normal and the patient was discharged from the hospital on 4 February 1974.

Discussion

A foreign body impacted in the oesophagus is a rare cause of failure to thrive. This possibility should be kept in mind in a child who is losing weight and where feeding difficulty and bouts of coughing are features.

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In our case the foreign-body appears to have been in the oesophagus for about three months as evidenced by the history, the state of the oesophagus, and the degree of corrosion of the nut removed.

The source of the nut was thought to be the baby's pram.

Summary

We report a case of a 'butterfly' nut removed successfully from the oesophagus of a 1-year-old baby. This foreign body was thought to have been present for three months. Continuous cough, feeding difficulty and weight loss were the predominant clinical features. The value of a chest X-ray is demonstrated.

Acknowledgements

We are grateful to Dr. Murphy, Consultant Physician, Temple Street Hospital, who referred this patient to our Department. Also our thanks to Mr. George Scully for his help and photography.

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https://doi.org/10.1017/S0022215100082852 Published online by Cambridge University Press