ŒSOPHAGEAL ABSCESS

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It is recognized that the structure and function of the œsophagus render it liable to trauma and infection. The resultant condition of localized abscess is described in the textbooks as sometimes following impaction of a foreign body, but it is difficult to visualize this in the thin and unsupported œsophageal wall.

References in the literature are surprisingly few, and for the most part relate details of para-œsophageal abscesses or mediastinitis rather than those of collections of pus in the œsophageal wall itself. In the references to which I have had access there is one case reported as a submucous abscess, of which I give a summary :

The case was one of impaction of a beef bone for eight weeks, and since obstruction was at first only partial, nothing was done until the patient's condition worsened and the obstruction suddenly became complete. This demanded urgent œsophagoscopy, but at operation a mounded area in the posterior œsophageal wall prevented access to the foreign body, whose presence was confirmed by a probe beyond the obstruction. Twenty-four hours later foul pus was evacuated spontaneously and a subsequent œsophagoscopy revealed the bone impacted in a bed of granulation tissue on the posterior œsophageal wall. Removal was accomplished and subsequent œsophagoscopies showed healing to be rapid and complete. It was then realized that the swelling had been the site of an abscess which had drained spontaneously.

I am now giving details of a case which appears to merit the description of an œsophageal abscess : A child, aged 3, was brought to Out-Patients by the parents, who said that it had swallowed a sixpence six weeks previously. Medical aid had been sought three days after the incident, but apparently no definite action was advised or taken. The reason for bringing the child to Hospital again was that for the last two days there had been vomiting after food, but previous to this no symptoms had been noticed. X-ray showed the shadow of a coin at the level of the Ist thoracic vertebra, but there was no obstruction to the passage of barium and no other abnormality in the chest was noticed. At œsophagoscopy a corroded coin was seen approximately 12 cm. from the incisor teeth. A potentially free passage was noted anteriorly, posteriorly and to the left of the coin, but the right edge was firmly adherent to the right lateral wall of the œsophagus. The coin was removed without difficulty and a semilunar impression corresponding to its edge was seen in the summit of a greyish moundlike thickening in the œsophageal wall. Removal of the coin released a quantity of very foul pus which was evacuated by suction. No interference was made with the area described above, but careful examination failed to reveal a fistula. It did not occur to me to make a culture, but the child was put on prophylactic sulphapyridine and sterile water by mouth for the first twenty-four hours. Recovery was uneventful, and a gradual return to normal diet produced no symptoms. Thirteen days later a barium

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swallow indicated the possibility of a shallow ulcerated area at the site of the impaction in the right lateral œsophageal wall. Three weeks later X-ray revealed no abnormality and the child had no symptoms. It has remained well since.

The interest of this case lies in the initial lack of anxiety as to the fate of the swallowed foreign body, the symptomless sojourn of the coin in the œsophagus and the formation of an apparently localized œsophageal abscess.

REFERENCE

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