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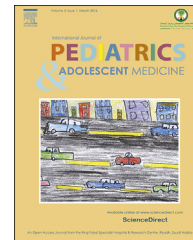


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INSTRUCTIVE CASE

Intramural esophageal foreign body in a child



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Abstract Foreign body ingestion is a common problem in the pediatric population. The majority of cases occur between 6 months and 3 years of age. Major complications, including bowel perforation and obstruction, have been reported. Forty percent of ingested foreign bodies are unwitnessed, and in fact, many are asymptomatic. We report the case of a 2-year-old girl who was referred to King Faisal Specialist Hospital and Research Centre, Riyadh, Saudi Arabia (KFSH&RC) with suspected congenital esophageal stenosis. Upon investigation, she was diagnosed with intramural esophageal foreign body.

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1. Introduction

Foreign body ingestion is a common case encountered in pediatric. Most of these cases result in no harm, a few cases have significant complications and rare cases remain unnoticed for some time.

Our case represents one of the unusual missed cases and was even labeled as congenital esophageal stenosis, an uncommon disease, after radiological and endoscopic studies.

2. Case presentation

A 2-year-old girl was referred to our center for further management of suspected congenital esophageal stenosis. Upon presentation, the patient was unable to tolerate a solid or pureed diet. She was vomiting and was having feed refusal in the last 6 months. She also had poor weight gain. No specific history of a preceding or predisposing event was

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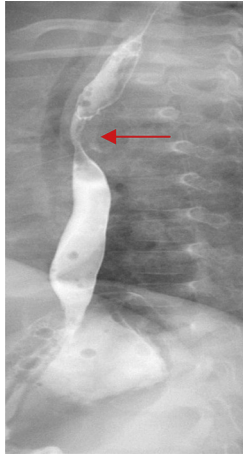


Figure 1 Barium swallow showing the esophageal stenosis in the mid-esophagus.

given by the family. The barium swallow study and esophagoscopy from the referring hospital indicated a severely stenotic area at the mid-esophagus.

A repeat barium swallow at our hospital showed a 1 cm long and 2–3 mm in diameter upper thoracic esophageal stenosis with proximal dilatation (Fig. 1). Esophagoscopy with dilatation, using a Savary-Gilliard dilator up to size 13, was performed. A month later, a second session of dilatation up to size 15 was performed. Following the second dilatation session, the patient’s status improved and she became asymptomatic. She was able to tolerate both liquid and solid food.

During the second esophageal dilatation, a hardening on the esophageal wall was noticed, so a chest CT was arranged to evaluate for the presence of a cartilaginous ring. However, the CT showed a focal inflammatory process in the upper thoracic esophagus surrounding an impacted esophageal wall tongue-like foreign body, most likely an aluminum can cover (Figs. 2–4).

The patient was admitted urgently. Repeat esophagoscopy showed a bulge in the esophageal wall with a slit-like area. However, the esophageal mucosa was grossly normal. No foreign body was identified. An exploratory



Figure 2 CT scan sagittal view showing the metallic foreign body as a curved hyperdensity posterior to the trachea (arrow).

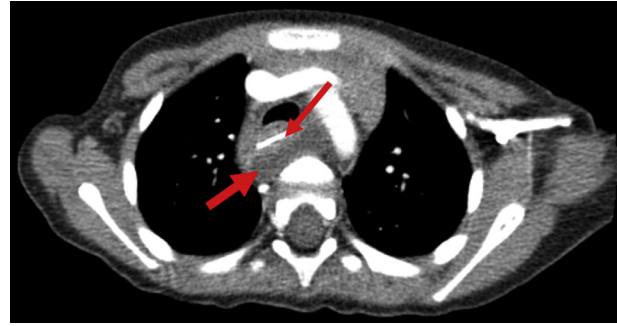


Figure 3 Axial CT scan with IV contrast showing the foreign body as a linear hyperdensity (narrow arrow) with a low attenuation posterior to it representing a posterior wall esophageal abscess (wide arrow).

thoracoscopy was performed. It revealed a cystic dilatation on the wall of the esophagus, which was accidentally incised and drained pus. The foreign body was identified and retrieved from the muscular layer of the esophagus (Figs. 5–7). The site of the esophageal break was repaired with primary sutures. Irrigation with normal saline was performed, and a chest tube was left in place. A specimen from the cystic wall was sent to the pathology lab and revealed submucosal fibrosis and unremarkable squamous epithelium. A culture was not performed.

The child was kept nil per mouth for five days, during which peripheral total parenteral nutrition was started.

Subsequently, a follow-up barium swallow was performed and showed interval improvement of the mid-esophagus narrowing with no leak (Fig. 8). The child was started on a liquid diet, which progressed to a normal-for-age diet, which she tolerated well with no complications. The chest tube was removed. She was discharged on post-operative day 6.

Retrospectively, a history of an episode of choking and vomiting along with the inability to tolerate oral liquids at the age of 13 months was identified. Initial investigation and management at that time revealed a whole bean,

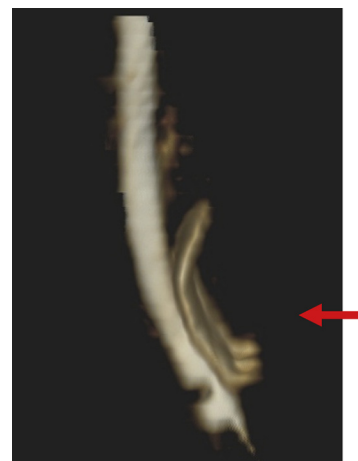


Figure 4 3D reconstruction showing the tongue like metallic foreign body (arrow) anterior to the inserted nasogastric tube

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