
CASE REPORT

Referral from a Teaching Hospital to Another

SAJID IQBAL SHEIKH, MAROOF AZIZ KHAN, SHAHZAD OMER FAROOQ

SUMMARY

We report an unusual case of impacted foreign body (bone chip) in esophagus of a 48 year-old gentleman. He presented to our OPD after six days with multiple attempts were performed at Allied hospital, Faisalabad (teaching hospital) 03-05-15, but was unsuccessful. It was removed successfully on 08-05-15 at Mayo Hospital Lahore, using a Jackson's adult rigid oesophagoscope by one single attempt. We believe this to be the first case of such a foreign body to be reported in the literature which was referred from another Teaching Hospital. (Allied Hospital).

Keywords: Bone chip, foreign body, oesophagoscope

INTRODUCTION

Majority of ingested foreign bodies, particularly if they are smooth or smaller than 12 mm in diameter will pass safely through the gastrointestinal tract. Severe problems such as perforation may occur in some circumstances, for instance, following ingestion of sharp objects, bone fragments, pins or long foreign bodies (greater than 6.5 cm)¹. The post cricoid region is the site of impaction of foreign bodies in 84% of the subjects. Impaction of a bolus of food in the distal esophagus in adults is frequently related to pre-existing stricture, diverticulum or tumor². Adult with non-food foreign bodies have a high incidence of psychiatric and social derangements. Most foreign objects will pass through the pylorus, although on occasion, some objects may remain in the stomach for a long period. Once beyond the pyloric canal most objects, even sharp edged foreign bodies such as pieces of glass or nails, will pass without harm until the terminal ileum which is again a site of predilection for impaction. Ingested foreign bodies may occasionally remain fixed in the caecum, ascending colon or sigmoid colon. Non contrast CT scan is indicated for diagnosing suspected upper esophageal foreign bodies not expected to be visible on plain radiography and in order to rule out perforation.

CASE REPORT

Forty eight year old gentleman, referred from Faisalabad (Bhawana), presented to the ENT Unit II, OPD at Mayo Hospital Lahore early morning on

Department of ENT, King Edward Medical University/Mayo Hospital, Lahore

Correspondence to Dr Sajid Iqbal Sheikh, Registrar ENT Email: madsajid@hotmail.com Cell: 0321-4496160

08-05-15 with complaints of difficulty in swallowing, pain on swallowing, drooling of saliva and pain in the chest following the accidental ingestion of foreign body (bone chip) while taking dinner six days back. First he reported to Allied hospital Faisalabad (teaching hospital) on 03-05-15, where he was admitted and all necessary measures were taken for removal of this foreign body (bone chip) but were not successful. He was then referred to Mayo Hospital Lahore in the benefit of the patient with request for removal. He was admitted in the best interest of patient in ENT UNIT II, to help such patient on request from other teaching hospital. He was known Diabetic and Hypertensive, without any past surgical history. At presentation there were no symptoms of respiratory distress or hoarseness. The physical and ENT examination was unremarkable except that the patient was looking anxious. On indirect laryngoscopy there was pooling of saliva in both pyriform sinuses. An X-ray of the neck lateral view shows opacification at upper end of esophagus. So a diagnosis of foreign body esophagus was made and the patient was subjected to rigid esophagoscopy under general anesthesia. Using an adult oesophagoscope, foreign body was seen at about 20 cm from incisor teeth which was about square in shape and was removed successfully on first attempt. A check esophagoscopy was done and revealed no injury to the esophageal mucosa. N/G tube was passed and patient was kept NPO for 48 hrs. after which oral feed was started. The post-operative period was uneventful. N/G tube was removed after 48 hrs.



DISCUSSION

A foreign body impacted in the esophagus requires immediate attention and treatment. Review of literature reveals that dysphagia (92%) and tenderness in neck (60%) are the most common clinical features. Majority (89%) patients come to the hospital within 24 hours. X-ray of the neck (lateral view) is the most useful investigation with presence of air in the esophagus being a significant finding⁴. Most foreign bodies are more or less radio opaque and will be readily recognized on a plain radiograph. Their progress in the bowel, if needed can be checked periodically. Ingested bone fragments appear as linear or slightly curved densities with sharp margins. However, some foreign bodies such as small fish bones or pieces of plastic and wood are

only faintly radio opaque and their detection may require a CT scan. Foreign bodies in hypo pharynx and cervical esophagus such as chicken & fishbone usually need radiologic workup. Non contrast CT scan may demonstrate these small calcified esophageal foreign bodies⁵. Indirect signs visible on plain radiography are soft tissue swelling and/or air due to edema or hematoma. In doubtful and suspected perforations oesophagography should first be performed with hydro soluble contrast medium to exclude perforation & study can then be completed with a barium examination. The contrast medium may impregnate the surface of the foreign body and render it more conspicuous. Radiographic signs of impaction in the distal esophagus are dilatation of the esophagus proximal to the obstruction with air fluid level as well as absence of air in the fundus of the stomach. Post-cricoid region is the site of impaction of foreign bodies in 84% of the subjects. The procedure of esophagoscopy is successful in 97% of the patients and fails in 3%. Coins are the most common foreign bodies (60%), followed by meat related foreign bodies (22.5%) and dentures in 5% cases. Complications occur in 18% patients and are more in adults (37.1%) compared to children (8.8%). The most serious complication is pneumo-mediastinum. Maximum complications occur with dentures (80%) and bone chips (42%)⁴. Foreign body in the esophagus is a serious condition and early removal by rigid esophagoscopy is recommended which is a safe and effective procedure. The other modalities of treatment involve removal with a laryngoscope in case of foreign bodies impacted in the pharynx, hypopharyngoscope for hypo pharyngeal foreign bodies and less easily foreign bodies are removed using a flexible esophagoscope. The common complications occurring while using a rigid oesophagoscope are injury to the lips, teeth tongue, palate and esophageal perforation which commonly occurs at the level of cricopharyngeal sphincter. Complications can be reduced if treatment is started within 24 hours of foreign body impaction⁶.

CONCLUSION

It is ethical to refer patients for specialist care if the need arises. A referral from a teaching hospital should be for the best interest of the patient's well-being and not the basis for some monetary gains for the attending surgeon. Also, referring should not be seen as an escape mechanism or route by a physician who refers difficult cases away so as not to make any effort to alleviate the patient's problems. It should not be done so as to keep a clean slate of no/or low deaths rate records in hospital since probably the doctor will refer out any severely ill

patient to other centers. Practitioners have an obligation to be certain that economic gain or desire to satisfy referral sources does not unduly influence the types and amount of therapy provided⁷.

Surgeons should not selectively refer patients with “good insurance” or those regarded as being well-to-do to the surgeons own practice, while they refer patients who are likely to generate less money to other centers of care. This is because self-referral is usually influenced by financial incentives⁸.

It was probably not unethical for the teaching hospital surgeons to want to refer out a patient because there was no available bed to admit the patient on. It would have been unethical to put him on the bare floor, when there were other hospitals nearby that can properly admit him onto a bed and administer proper treatments. Also it's unethical to make a patient life in danger by putting them under the knife if the expertise is not available.

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