though tricksters, may yet be mentally, and sometimes physically, ill; and that we who are not can, as well as being clever, also be kind.

How can cases of Munchausen syndrome be recognised early in the consultation? The clinician's suspicion remains all important.

We thank Mr R Touquet and Dr T Challoner for their advice and assistance in the production of this case report. The tracking of the case by Pamela Dymek is gratefully acknowledged.

Oesophageal perforation: a rare complication of minor blunt trauma

G L A Cumberbatch, M Reichl

Abstract
Oesophageal perforation following blunt trauma is rare and accounts for less than 10% of all oesophageal ruptures. Review of published reports revealed only two cases of isolated oesophageal perforation after minor blunt trauma, and these were as a direct result of the Heimlich manoeuvre.

This paper describes a case of perforation of the oesophagus as an isolated injury following blunt minor trauma. (J Accid Emerg Med 1996;13:295-296)

Key terms: minor blunt trauma; oesophageal perforation.

Review of published reports revealed only two cases of isolated oesophageal perforation after minor blunt trauma, and these were as a direct result of the Heimlich manoeuvre. We present a case of perforation of the oesophagus as an isolated injury following blunt minor trauma.

Case report
A 26 year old man presented to our accident and emergency (A&E) department complaining of neck swelling and dyspnoea, following a blow to the interscapular region of his back during a rugby match. He initially felt "winded" and immediately stopped playing, arranging his own transport to the hospital. On arrival he also complained of dysphagia and a change in his voice.

He had no significant past medical history. On examination he was apyrexial, had a pulse rate of 62/min, a respiratory rate of 24/min, a blood pressure of 139/65 mm Hg, and oxygen saturation of 99% on air. He had obvious surgical emphysema extending from the root of his neck down to the nipple line bilaterally. The rest of the physical examination was unremarkable.

Chest radiography (fig 1) revealed marked subcutaneous surgical emphysema, a pneumomediastinum, and a very small apical pneumothorax. Lateral cervical spine x ray (fig 2) showed a large volume of air in the prevertebral space, with anterior displacement of the pre-vertebral fascia.

A clinical diagnosis of ruptured oesophagus was made. Iohexol (Omnipaque) swallow was arranged urgently and confirmed a perforation in the upper one third of the oesophagus.

He was admitted to the surgical ward and treated conservatively, with intravenous anti-
more difficult following blunt trauma, as often
the presenting features are those of the
associated injuries, for example pneumo-
thorax, haemothorax, or flail chest.

A previous search of published reports on
perforation of the oesophagus by blunt external
trauma reviewed 63 cases and detailed the
mechanism of injury, associated injuries, clinical
findings, and outcome. In all but two
cases the mechanism of injury was significant
trauma, mostly due to road traffic accidents
and falls. These two exceptions were cases of
trauma from the Heimlich manoeuvre; no
cases were caused by minor sports injury.

The study showed that patients had a variety
of symptoms, namely dysphagia, dyspnoea,
hoarseness, neck pain or swelling, and chest or
abdominal pain. Physical signs were absent or
appeared only as neck or chest wall surgical
emphysema. Radiography of the chest revealed
subcutaneous air, pneumomediastinum or
pneumothorax, while lateral cervical spine x
ray showed air posterior to the prevertebral
fascia.

Our patient had most of these clinical
features and hence the diagnosis was made
relatively easily. However, if surgical emphy-
sema had been absent or not noticed the
diagnosis would have been easily missed.

This case shows the importance of sus-
pecting a ruptured oesophagus when there are
suggestive clinical features, even in the absence
of severe blunt trauma to the chest or abdomen.

We are grateful to Gabbie Valentine for help in the preparation
of the manuscript.

1 Haynes DE, Haynes BE, Yong YV. Esophageal rupture
2 Meredith MJ, Liebowitz R. Rupture of the oesophagus
3 Sandra L, Rea MD, Edward W, Potmeyer MC, Johnese
M, Spisso RN. Esophageal perforation following blunt

Uncomplicated penetrating colonic injury

T O Oshodi, D Bowrey

Abstract

The case of a patient with an air gun pellet
injury to the right colon is reported. This
was treated conservatively, and the pellet
was passed per rectum 12 hours after the
injury. Gunshot wounds to the abdomen
do not necessarily warrant immediate
laparotomy. Sieving of bowel motions
may identify if the foreign body has been
passed.


Key terms: gunshot wound; colon penetration

Gunshot abdominal injuries are uncommon in
the United Kingdom but account for 47% of
cases of abdominal trauma in the USA.1 The
treatment of such injuries was controversial
until recently.2 We report a patient with an air
gun pellet injury to the right colon treated
conservatively, and the passage of the foreign
body per rectum 12 hours after the injury.

Case report

A 44 year old obese man presented two hours
after he was accidentally shot with an airgun
from a distance of 8 feet. Clinically he had a
small entry wound in the mid right flank
without signs of peritonism. Plain abdominal x
ray (figure) showed the airgun pellet lodged
within the abdomen. Full blood count,
including amylase, and urine analysis were
normal. He was placed on antibiotics and

Figure 2  Lateral radiograph of the neck with significant
prevertebral air extending to the skull base.
Oesophageal perforation: a rare complication of minor blunt trauma.

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