

Foreign body in the hypopharynx – an unusual presentation

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Abstract

A case is described of a foreign body (a metallic paper clip) in the hypopharynx of an 18 month old child presenting with recurrent respiratory tract infections. The child was treated with antibiotics at two accident and emergency departments without any benefit. A high degree of suspicion is necessary in young children, as a history of ingestion of a foreign body may not be forthcoming. It is important to be aware of the possibility of a foreign body in young children, particularly when the clinical presentation is atypical.

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Key terms: hypopharynx; foreign body

A foreign body in the upper aerodigestive tract is not an infrequent cause of respiratory symptoms in young children. These can go undetected, particularly when a history of ingestion in children is not forthcoming.¹ We present a rare case of an 18 month old child with a metallic paper clip in the hypopharynx.

Case report

An 18 month old child presented to our department with a history of noisy breathing for 6-8 weeks. On clinical examination the child had stertor, which was consistent with retained secretions in the pharynx. She was afebrile with no evidence of torticollis or hyperextension of the neck. Examination of oropharynx showed no abnormality except for a slightly inflamed posterior pharyngeal wall. The hypopharynx could not be well seen. There was no lymphadenopathy in the neck.

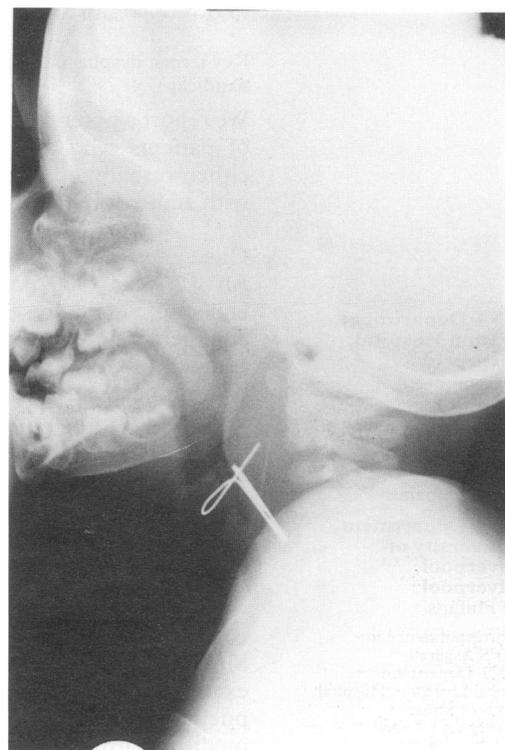
The white cell count was raised at 16.1×10^9 /litre. A lateral soft tissue of the neck showed a metallic paper clip, stuck by its partially unfolded limb (figure) to the posterior pharyngeal wall at the level of the hypopharynx between the C4-C5 cervical vertebrae. There was evidence of retropharyngeal cellulitis with widening of prevertebral space.

The nomadic lifestyle of the family resulted in the child being treated with antibiotics at two accident and emergency (A&E) departments for respiratory tract infections, without any benefit. Although the history of foreign body ingestion was not forthcoming, the mother later remembered that the child was playing with a box of paper clips eight weeks earlier. A course of intravenous antibiotics was begun and the paper clip was removed under anaesthetic, after which the child made an uneventful recovery.

Discussion

Foreign body ingestion in children is not uncommon. The diagnosis is usually straightforward in adults and older children. In pre-lingual children the diagnosis of a pharyngeal foreign body may pose a problem,¹ particularly when the history is not forthcoming, as in our patient. Foreign bodies in hypopharynx usually present with dysphagia, pain, and excessive salivation. In young children symptoms can be atypical, with refusal to eat or drink, drooling, stertor, or symptoms of respiratory tract infection. Localisation of the foreign body is reliable in the adult if it is located above the cricopharynx.² We stress the importance of eliciting an adequate history in the A&E department, particularly in young children.

Undiagnosed retropharyngeal foreign bodies can result in retropharyngeal cellulitis or abscess. Retropharyngeal abscesses are relatively common in children, and are usually secondary to oropharyngeal infections³ and foreign bodies. The history and clinical examination may provide a clue to the diagnosis. A lateral radiograph of the neck is the single most valuable investigation in the evaluation of retropharyngeal space,³ although its routine



Lateral view of the neck showing the paper clip.

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use has been questioned.⁴ Widening of the retropharyngeal space is suggestive of cellulitis or abscess formation.

In conclusion, we describe a rare case of an 18 month old child with foreign body in the hypopharynx presenting with recurrent respiratory tract infections. Since the ingestion of the foreign body was unnoticed there was a delay in the diagnosis. We stress the importance of increased awareness of foreign body ingestion in children in the A&E department, particu-

larly when the history is unreliable or if the clinical symptoms are atypical.

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A case of Munchausen syndrome with claims of trauma and haemophilia

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Abstract

A case of Munchausen syndrome presented with both factitious trauma and factitious haemophilia. He was treated inappropriately with factor VIII concentrate before the history of the presenting complaint could be validated. Clinical suspicion remains the most important aid to diagnosis.

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Key terms: Munchausen syndrome; trauma; haemophilia

We report a case of Munchausen syndrome presenting with both factitious trauma and factitious haemophilia.

It is uncommon for cases of Munchausen syndrome to present with trauma as it is very hard to fabricate. Munchausen syndrome presenting with trauma is not the same condition as deliberate self harm but can be as perplexing.

In reply to Asher's original article,¹ a letter in the *Lancet* correspondence columns described a casualty presenting with the symptom of haemoptysis which he said began after a lorry crash in Scotland.² A case report³ of fabricated trauma 40 years later described the presentation of a man covered in blood who said that a heavy crate had fallen on his chest. The blood came from a facial cavernous haemangioma and the history was increasingly suspicious. In both these cases there was no substantiated trauma.

Factitious haemophilia has been reported in more than one case of Munchausen syndrome. Cases of Munchausen syndrome with false claims of haemophilia have been reported, as have cases of Munchausen syndrome with false claims of haemophilia who then claim to have developed AIDS from contaminated factor VIII transfusion.⁴ There is a case report of a

mother with Munchausen by proxy who then developed true Munchausen syndrome and by presenting with psychogenic bleeding duped doctors into treating her for presumed haemophilia and von Willebrand disease.⁵ Our case has been reported more than once with false claims of haemophilia and HIV positivity.

Case report

A 30 year old man was brought by ambulance to the accident and emergency department of St Mary's Hospital Paddington following liaison with the police. The history from the patient was that one hour earlier he had been riding a bicycle when a car had hit him from behind. He said that he had been propelled forward into a second oncoming car and had catapulted over the handlebars onto the ground. He said that he had not been run over and that both drivers had absconded with their respective vehicles from the scene. The police were called by an unknown person who found the man lying in the road next to his bicycle. No other vehicles involved were seen by the police.

On arrival the cyclist was seen immediately by one of us (AH) who assessed and managed the patient according to ATLS guidelines.

His airway was not at risk and the cervical spine was immobilised. The respiratory rate was 12/min with 99% oxygen saturation on 12 litres of oxygen/min. Auscultation of the chest was unremarkable, with good air entry bilaterally. His pulse rate was 67 beats/min with a blood pressure of 110/70. There was no clinical evidence of external bleeding and peripheral perfusion was normal. He was alert and orientated with equal sized reactive pupils and no focal neurological signs.

From the ATLS primary survey there was no sign of any life threatening trauma but because of the history of the mechanism of injury two large bore intravenous cannulae were inserted

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