biotics and enteral feeding through a fine bore feeding tube which was inserted under x ray guidance.

The patient made an uneventful recovery and was discharged after 10 days, when he was able to tolerate solids orally. No follow up was thought necessary.

Discussion
The clinical diagnosis of ruptured oesophagus is always difficult. A high suspicion of this injury is essential to prevent missed or delayed diagnosis, as its complications carry a significant mortality. The diagnosis is even more difficult following blunt trauma, as often the presenting features are those of the associated injuries, for example pneumothorax, haemothorax, or flail chest.

A previous search of published reports on perforation of the oesophagus by blunt external trauma1 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 emphysema had been absent or not noticed the diagnosis would have been easily missed.

This case shows the importance of suspecting 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.


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
Sesamoid bone interposition complicating reduction of a hallux joint dislocation

S J Ward, Ray P Sheridan, I G Kendall

Abstract
This is the first reported case of sesamoid bone interposition in the interphalangeal joint of the hallux as a complication of closed reduction of a dislocated interphalangeal joint of the hallux. The case also highlights the importance of post-reduction radiographs.

Case history
A 20 year old worker presented to the accident and emergency department. He described sustaining a "stubbing injury" to his right hallux during a football match. Examination revealed a tender right hallux with dorsal angulation. Radiographs revealed a dislocated interphalangeal joint which was reduced using Entonox and closed manipulation. Post-reduction radiographs showed sesamoid interposition at the interphalangeal joint with a widened joint space. A repeat manipulation using a bupivacaine digital nerve block reduced the sesamoid bone into the correct position and further radiographs confirmed this (figs 1–3).

Discussion
Sesamoid bone interposition as a result of the initial injury at the interphalangeal joint of the hallux is a recognised but rare occurrence.1-7