

such as a chronic skin ulcer. There have been reports where no evidence of an initiating injury was found. There is a higher incidence of necrotising fasciitis associated with diabetes mellitus, obesity, advancing age, and atherosclerosis.^{6,7} The primary treatment for necrotising fasciitis is early aggressive surgical debridement after initial resuscitation.

Early intravenous broad spectrum antibiotics should be given until culture results dictate specific antimicrobials. Some clinicians strongly advocate the use of hyperbaric oxygen,⁸ though evidence for the value of this is lacking.⁹ If hyperbaric oxygen is to be employed it should not delay surgical intervention. Mortality varies with the interval from the onset of the disease and its treatment, but has been reported to be as high as 70-80%.^{10,11}

Necrotising fasciitis specifically following steroid injection has been reported previously.^{12,13} Steroids are well known to have an inhibitory effect on leucocyte function, both locally and systemically, and may have been a predisposing factor in our patient. Steroids inhibit monocyte chemotaxis as well as the production of interleukin 1 and other monokines.¹⁴ They reduce phagocytosis and the production of prostaglandins, thromboxanes, and leukotrienes.^{15,16}

Our patient had also recently been started on non-steroidal anti-inflammatory drugs which, through their effect in lymphopenia and depression of lymphocyte function, have been specifically implicated in the pathogenesis of necrotising fasciitis.^{17,18} No other predisposing condition was present.

There is a small possibility that the Depo-Medrone with lignocaine could have been contaminated, although the GP reported he had

not had any problems from any other drugs in the same batch. The Committee on Safety of Medicines and the drug company were contacted. The drug company had not had any other cases reported to them.

Where a diagnosis of necrotising fasciitis is suspected, early aggressive surgical treatment after the initial resuscitation is essential if mortality and morbidity is to be prevented.

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Oesophageal “cross” — a sinister foreign body

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Abstract

A young jail inmate purposely ingested a foreign body formed of sewing needles, specially designed to be arrested in the gut and cause perforation. Immediate surgical removal of such ingested foreign objects is recommended because the chances of distal passage are nil.

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Keywords: oesophagus; self inflicted perforation; foreign body

Case report

A 23 year old prisoner presented with dysphagia of 10 hours' duration. He gave a history of having purposely ingested a metallic foreign body 16 hours previously in an attempt to escape jail temporarily. Chest x ray showed a

rather unusual foreign object which appeared to be situated within the cervical oesophagus (figure).

Following uncomplicated surgical removal, the patient explained how he made the device. Two sewing needles, each measuring approximately 5 cm, are tied crosswise with a rubber band, thus forming a “cross”. The construction of the cross is elastic—its two branches can be pulled together, but when released they return to their original position. With the branches lying parallel, the cross is wrapped in a small strip of paper and then ingested with some water.

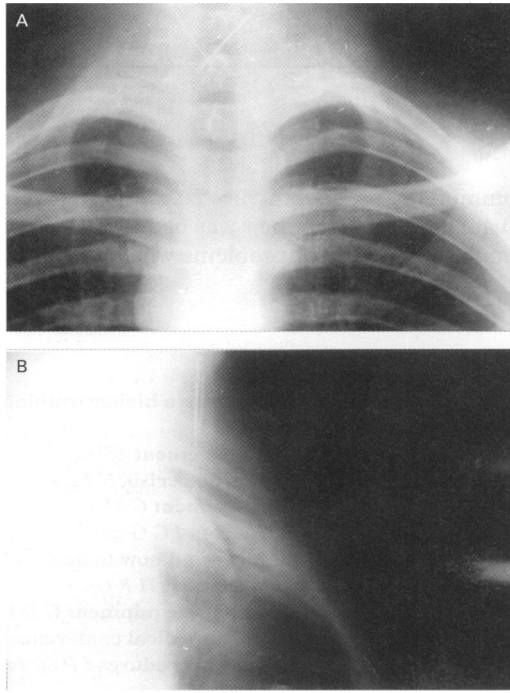
Discussion

The foreign body created and ingested by our patient warrants special consideration because it has two potential puncturing points, cranial

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(A) Antero-posterior x ray of the chest showing a radio-opaque "cross" constructed from two sewing needles. The foreign body appears to be in the cervical oesophagus. (B) Lateral view, showing the two branches of the foreign object located in the boundaries of the cervical oesophagus.

and caudal. Thus it seems dangerous or even impossible to remove it with safety endoscopically once it has been released from its wrapper.

Based upon the present experience, and upon our previous experience with five patients in whom multiple ingestions of "crosses" inevitably led to perforations of the stomach, duodenum, and small intestine in each instance,¹ we recommend immediate surgical removal for any such type of ingested foreign object because the chances of distal passage are nil.

Finally, our case appears to be the first case with oesophageal location of a "cross". Of special interest is the fact that this sinister foreign body was specially designed to arrest in its passage and cause perforation.

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