

side effect of Ciprofloxacin. It is mentioned as unusual side effect of another quinolone Nalidixic acid(2) but not of Ciprofloxacin.

N.S. Deshpande,
*Yashwantrao Chavan Memorial Hospital,
Pimpri Chinchwad Municipal Corporation,
Pimpri, Pune 411 018.*

REFERENCES

1. Karande SC, Kshirsagar NA. Adverse drug reaction monitoring of Ciprofloxacin in Pediatric Practice. *Indian Pediatr* 1992, 29: 181-188.
2. Illingworth RS. Common Symptoms of Disease in Children, 5th edn. Singapore, Blackwell Scientific Publications, 1975, pp 180-181.

Unusual Foreign Body (Stone) in the Esophagus of a Neonate Mimicking Tracheoesophageal Fistula

Foreign body (FB) in the esophagus during neonatal life is a very rare occurrence(1,2). Elder sibs in the family put FB in the oral cavity of infants without realizing the consequences. Suddenly, the FB get swallowed in and obstruct the esophagus. We managed a 45-day-old infant with a foreign body stone in the esophagus, put in the oral cavity by elder sib at the age of 13 days of life. He had respiratory distress and dysphagia mimicking tracheo-esophageal fistula.

A 45-day-old male infant was hospitalized with history of cough, choking, he-

matemesis and excessive froth in the mouth since the 13th day of life. He was born to primigravida mother at term by normal vaginal delivery in a hospital without any adverse perinatal factors and was breast fed. On 13th day of life, the mother noticed sudden choking, cough, respiratory distress and froth in the mouth while the baby was in the lap of elder sib. The baby had hematemesis and malena subsequently. He was put on breast feeds. He tried sucking initially but was tired and could not swallow the milk as it came out by the angle of the mouth. His condition deteriorated and he was admitted in local medical college with the diagnosis of bronchopneumonia. He was kept nil orally and was given intravenous fluids (IV) and antibiotics. He received one blood transfusion. On showing a little improvement, breast feeding was retried. However, again he could not swallow and had excessive frothing and a bout of severe cough. Subsequently, he was given Ryle's tube feeding but his respiratory distress did not improve. Meanwhile, he had two more episodes of hematemesis and malena. On the 37th day of life, he was referred to PGIMER, Chandigarh with a diagnosis of tracheoesophageal fistula (TOF). He remained in the Pediatric emergency ward for 7 days and was managed as aspiration pneumonia but when oral feeding was started he again had severe choking followed by respiratory distress. All the investigations including barium meal done by instilling thin barium through Ryle's tube were reported normal. Pediatric Gastroenterology consultation was called for exclusion of TOF. The whole history was reviewed and possibility of foreign body was kept in mind. At 45th day of life, on review of the X-rays of chest, a foreign body in upper one third of esophagus was suspected (*Fig. 1*) and subsequently was confirmed under fluoroscopy. On the same day, upper gastrointestinal

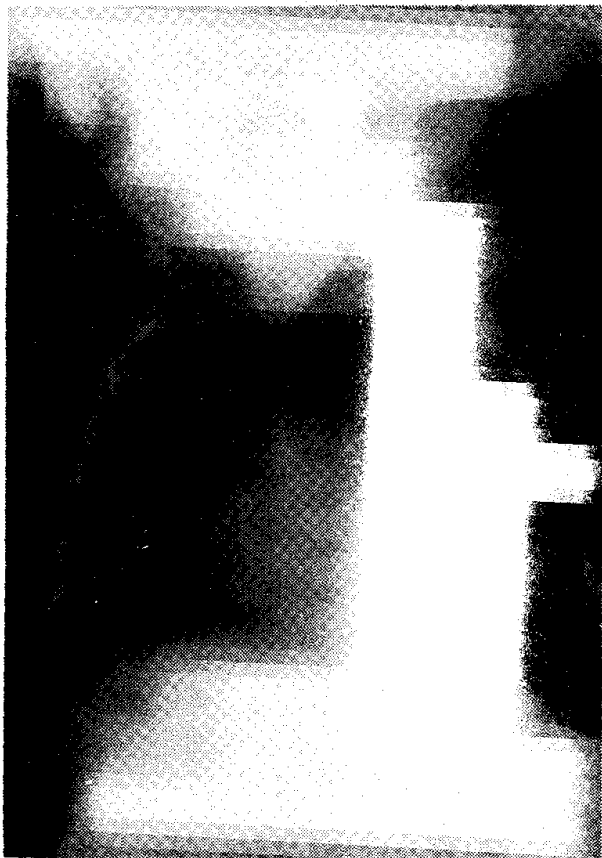


Fig. 1. X-ray chest PA showing the foreign body.

endoscopy was done with fiberoptic endoscope and a stone was identified in the upper part of esophagus which was taken out with dormia basket under direct vision without sedation or anesthesia. Subsequently, the baby showed remarkable improvement. The drooling of secretions stopped, respiratory distress became passive and he started taking breast feeding without problems. On 4th day he was discharged. On follow up he is gaining weight and had no respiratory difficulty.

Foreign body (FB) in the esophagus constitutes a serious emergency in Pediatric practice. Esophagus is a tubular structure and its whole length lumen is narrow in children. There are physiological narrow areas like cricopharyngeal part, mid esopha-

gus and gastroesophageal junction. In children under the age of 3 years the impaction of FB is common(1,2). Impaction of FB in esophagus had been reported in older children and adults(3). But this depends upon the size and nature of FB. To the best of our knowledge this is youngest patient with stone as FB in the esophagus. There is no mention of FB in the alimentary tract of neonates even in standard text books of Pediatrics and Neonatology. Moreover, stone being a FB is very rare in older individuals also. There is no mention of stone as FB in esophagus in the large studies reported in the literature. In the present patient, possibly the stone was put in the oral cavity by the elder sib on 13th day of life and was swallowed simultaneously by the neonate. This obstructed the narrowest area of esophagus and was responsible for the clinical picture in him but diagnosis was missed all through. Respiratory distress is the commonest manifestation of esophageal FB in younger children(1). The manifestation in the present neonate exactly mimicked tracheoesophageal fistula like severe choking, respiratory distress, drooling of secretions and dysphagia for 32 days. He had aspiration pneumonia due to lack of clearance of secretions. Various factors leading to respiratory distress are edema around the FB in larynx and trachea, tracheal compression, edematous laryngeal inlet, periesophageal reaction and overflow of secretions in the tracheobronchial tree(1-4). All the factors were operating in the present case. Very rarely hemorrhage has been reported due to ulceration caused by impacted FB. The present patient had significant upper gastrointestinal bleeding evidenced by hematemesis and malena and required transfusion. Various other complications of FB in esophagus can be perforation, mediastinitis and fistula formation(1,6).

Removal of FB from esophagus is a challenge though various methods like use of Folley's catheter, rigid endoscope and Valsalva manoeuvre have been used(1,5). However, fiberoptic endoscopy has revolutionized(6) the management as exemplified by the present patient.

Ingestion of FB should be kept in mind while managing a neonate or infant with respiratory distress, aspiration pneumonia, dysphagia and upper gastrointestinal bleeding. The management of esophageal FB is entirely different. Experts trained in Pediatric endoscopy and appropriate size endoscopes are required to properly handle the neonates and infants. The results are dramatic and rewarding and surgery can be avoided.

**B.R. Thapa,
Balwinder Kaur,
B. Nagi,
J.B. Dilawari,**

*Division of Pediatric Gastroenterology,
Post Graduate Institute of
Medical Education and Research,
Chandigarh 160 012.*

REFERENCES

1. Silverman A, Roy CC. Foreign bodies in alimentary tract. *In: Pediatric Clinical Gastroenterology*, 3rd edn. St Louis, CV Mosby Company 1983, pp 186-187.
2. Ellis PDM, ARdan GM. Esophageal foreign bodies in an infant. *J Laryngol Otol* 1973, 87: 691-698.
3. Beg MH, Reyazuddin. Esophageal foreign body: An unusual presentation. *Indian Pediatr* 1988, 25: 464-465.
4. Chaturvedi VN, Raizada RM, Behl R, Hasan W. Esophageal foreign body: Unusual mode of entry and presentation. *Indian J Chest Dis Sci* 1982, 24: 40-42.
5. Carlson DH. Removal of coins in the esophagus by using Foley's Catheter. *Pediatrics* 1972, 50: 475.
6. Christie DL, Ament ME. Removal of foreign bodies from esophagus and stomach with flexible panendoscope. *Pediatrics* 1976, 57: 931-934.

NOTES AND NEWS

LAKE SIDE EDUCATION TRUST ANNUAL CME PROGRAMME

The Lake Side Education Trust is organising its 11th Annual CME Programme on *Sunday 25th July 1993* at Hotel West End, Bangalore. Distinguished speakers from across the country will speak on the topic of Rational Drug Therapy in Pediatrics followed by Panel Discussion and a one hour pre-zonal Pediatric Quiz.

For registration/details of the programme, please contact or write to:

Dr. H. Paramesh,
Chairman, Organizing Committee,
Lake Side Education Trust,
33/4, Meanee Avenue Road, Bangalore 560 042.
Tel. 566723/566738