Incidental recognition of an aspirated tablet in an oesophagectomized patient

Editor—We report an incidental recognition of silent aspiration of a tablet given before operation during routine fibreoptic inspection of the double-lumen tube position in a patient with a previous oesophagectomy.

A 64-yr-old woman presented with a carcinoma of the middle oesophagus. An abdomino-thoracic oesophagectomy was combined with the gastric pull-up technique. Two months after the primary intervention, the patient required surgical treatment of a persistent chylothorax. On the day of operation, the patient received her oral medication (including diclofenac 50 mg) without any sedatives. No opioids had been given in the previous 48 h. A rapid-sequence induction was performed and the trachea was intubated with a 37 F left-sided double-lumen tube. The correct positioning of the tube was verified by bronchoscopy and incidentally, a tablet was recognized in the right main bronchus. The tablet was too large to be extracted through the double-lumen tube. Therefore, the tube was replaced by a single-lumen tube (inner diameter 7.0 mm), the tablet was aspirated to the tip of the bronchoscope with the suctioning channel and transferred into the tube. Then, the tube together with the tablet and the bronchoscope were carefully removed. Subsequently, the double-lumen tube was reinserted, the whole bronchial tree was re-inspected and the operation started as scheduled. Laboratory analysis of the tablet revealed that the main component was diclofenac. This result fitted to size and colour of the extracted tablet.

Aspiration of gastric content is a common problem after oesophagectomy and responsible for the high incidence of pulmonary complications in these patients.1–3 This case demonstrates that asymptomatic aspiration of a solid tablet can occur even nearly 2 months after oesophagectomy.

Another important aspect of this case is the difficulty to remove a moist tablet without disintegration within the bronchial tree. Although many approaches to remove endobronchial foreign bodies have been described (like rigid or flexible bronchoscopy assisted by wire baskets, bronchoscopic forceps,4 Fogarty balloon catheters,5 and fluoroscopic guidance of instruments6), they often require special instruments and skills. The smooth and fragile consistency of a moist tablet is at risk of disintegration and dispersion into the bronchial tree. Thus, extraction of a tablet by suctioning it into the tracheal tube is a simple and immediately available approach, which does not require special skills or instruments. The risk of accidental endobronchial injury is reduced in the absence of potentially hazardous instruments like endoscopic forceps, baskets, or Fogarty catheters. In addition, the tablet is secured inside the tube while retrieving it through the trachea, glottis, and pharynx avoiding the loss or disintegration of the tablet. This technique of retrieving a foreign body ‘en bloc’ with the tube has already been described, but only in combination with complex instruments like baskets or forceps.7 This case demonstrates the possible risk of silent aspiration of solid foreign bodies after oesophagectomy even months after the initial operation. Furthermore, the presented procedure to remove a fragile foreign body without the risk of unintended disintegration as described in this case appears to be a feasible, simple, and safe technique.

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Editor—Familial Mediterranean fever (FMF) is a hereditary syndrome characterized by recurrent episodes of fever and serositis. Onset of an episode of FMF is sudden and acute, with rapid development of symptoms within 1–2 h.1 Although it is not clear how attacks are triggered, they may be precipitated by emotional stress. Anaesthesia for patients with uncomplicated FMF does not present any particular problems.2 However, anaesthesia and surgery are associated with emotional and physical stress that might trigger FMF attacks.3 We report an FMF episode that developed immediately after spinal anaesthesia for pilonidal sinus surgery.

A 20-yr-old male was admitted for pilonidal sinus surgery. He had been taking colchicine 2 mg day−1 for treatment of FMF for 3 yr. He had no episodes within the last year. After placement of routine monitors, we gave hyperbaric bupivacaine 0.5% (10 mg) intrathecally through a 25 gauge needle at the L4–5 interspace with the patient sitting. Immediately after administration, the patient complained of severe abdominal pain while he was in the sitting position. The patient said the pain is just like the one in an FMF crisis. The patient was placed in the Trendelenburg position to increase the level of blocks. Ten minutes later, pinprick block level was T8 and the patient was still having severe abdominal pain. The patient returned to the supine position, and diclofenac 75 mg and fentanyl 100 μg were given i.v. to reduce the pain. Within 8 min, the pain was resolved completely. The patient gave permission to proceed with the surgery. The surgery was started when the pinprick block level was confirmed to be at least two dermatomes higher than the surgical field. The abdominal pain did not repeat within the first 48 h after the surgery.

Abdominal crisis occurs in 95% of the patients with FMF.1 Treatment with colchicine is an effective preventative treatment, but it is ineffective for the treatment of established acute attacks. A crisis may be started by stress factors such as anaesthesia and surgery.3 The pain may be refractory to non-steroidal anti-inflammatory drugs and opioids.4 We thought placement of patients in the Trendelenburg position might help to extend the analgesic level of the local anaesthetic, but this did not ease the pain. In our case, the crisis was treated successfully with fentanyl and diclofenac. Such crises may develop in patients with FMF during spinal anaesthesia. When applied anaesthesia level is insufficient to resolve the abdominal pain, fentanyl may be a good option. We wish to draw attention to this potential problem during spinal anaesthesia in patients with FMF.

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