but we were not able to grab it (Supplementary Video 1). Next, we performed gastroscopy, which revealed a round, white, frothy mass within an ulcerated lesion located in the fundus. It looked like a effervescent tablet that had not dissolved. Unfortunately it was fragmented during the salvage attempt and could not be totally extracted (Supplementary Video 2). Postoperative CT scan showed the residual fragments of the foreign body and also a pancreatic cyst (Fig. 2). The extracted fragment of the foreign body was fully dissolved in saline within four hours, so no further tests were required. In his preoperative course, the patient received calcium substitution with effervescent tablets (Maxi-Kalz 1000 mg, Meda Pharma, Vienna, Austria). Our explanation is a preoperative intake of a effervescent tablet that did not dissolve, which misguided us to re-sternotomy.

SUPPLEMENTARY MATERIAL

Supplementary material is available at ICVTS online.

eComment. Radio-opaque foreign bodies in a chest X-ray

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I read with interest the article by Vötsch et al. In cases of the presence of a radio-opaque foreign body in the chest X-ray, we should localize it either in the pleura, mediastinum, airway, esophagus or parieties. Treatment depends on the exact site of the foreign body.

The main problem comes from misinterpreting the site of the foreign body. Proper localization of the foreign body in the chest requires not only a detailed and thorough history-taking from the victim and/or family, but also chest X-rays, at posteroanterior and lateral views with clothes off to overcome malingering psychotic patients. Not infrequently, 24 to 48 hours of observation may help to localize the chest foreign body properly - whether ingested, inhaled, self-inflicted or even forgotten intraoperatively. It may save some unnecessary scopies and/or explorations. The reported case [1] and a case of mine [2] are good examples that reiterate these rules.

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References