Esophageal perforation caused by a dental prosthesis

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CASE REPORT

An 83-year-old patient with dementia was admitted because of complaints of cervical discomfort, without respiratory symptoms, after what she described as having swallowed her dental prosthesis. There were no pathological findings in objective examination.

The patient underwent thoracic radiography showing a radiopaque foreign body in the cervical region in a format compatible with the history provided (Figures 1 and 2).

Endoscopic evaluation revealed that the more cephalic portion of the prosthesis was at the epiglottis level, with no possibility of endoscopic removal due to apparent resistance to mobilization.

During the maneuvers to prepare intubation and protect the airway, the prosthesis was found mobile and was removed with a Magill forceps. After that procedure, on inspection with the laryngoscope, no lesions were found, and by that time we no longer had the possibility to perform an endoscopy.

The same day cervicothoracic computed tomography described cervical and mediastinal subcutaneous emphysema (Figure 3).

During surveillance, nil per os, antibiotic therapy and proton pump inhibitor were provided. Therapy with Piperacillin-Tazobactam and Vancomycin was chosen, but due to the worsening of the clinical condition, it was necessary to add antifungal therapy on the fifth postoperative day, although the revaluation computed tomography of this date did not reveal the existence of any collection. On the tenth postoperative day, an oral contrast study with gastrografin revealed no leakage and oral diet was resumed uneventfully.

DISCUSSION

Despite being more often in children, foreign body ingestion also occurs in adults, especially those with cognitive impairment, like the patient of this case report.

The usual location of the impaction is the cervical esophagus, for anatomic reasons, but that also depends
on the size and shape of the object. The object described in this case is a major challenge because of its size and the presence of several sharp hooks and therefore its removal by endoluminal route without any, at least, mucosal esophageal injury would be unlikely. The prosthesis was removed because it looked mobile and we cannot know if the full-thickness perforation confirmed by the emphysema occurred previously or at that maneuver. Since the timetable of access to urgent endoscopy is limited in our hospital, and the patient showed no signs of bleeding, the patient was admitted for surveillance. Broad spectrum antibiotics were started as recommended.

Given the patient’s good clinical course after antifungal therapy was introduced, no further measures were taken. If we had endoscopy available, we could have tried to seal the leak with clips, but this strategy is not recommended when it has been several hours since the perforation. The use of endoluminal covered stent to seal the perforation was not an option because of the presumed location of the lesion in the cervical esophagus [1, 2].

CONCLUSION

Most small cervical perforations in healthy tissue without distal obstruction have a good prognosis with conservative treatment when the broad spectrum antibiotics are started within the first hours.

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Authors declare no conflict of interest.

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