Case History

1. GERALDINE STROM ECHUCA.

A+

Anne, 8 years, a happy well cared for little girl, with no previous history of significant illness, was rushed, by her parents, to the hospital of the country town where they lived, after she swallowed a prune stone at lunch.

Anne was choking for breath, blue in the face and distressed when she arrived at the hospital. She was examined by an attending doctor who ordered an immediate X-Ray. Anne vomited her lunch but did not appear to dislodge the stone even though her breathing became easier. The X-Ray showed an opacity towards the distal end of her trachea and it was decided to send her immediately to a city hospital, 60 miles away, for further treatment. She was accompanied to the city hospital with a member of the trained nursing staff and her mother, in an ambulance:

On admission to the casualty section of the city hospital some hours had lapsed since the incident and although Anne complained of a sore throat she was not reported to be in a distressed condition. Her observations were within the normal range and another X-Ray detected no abnormality.

The admitting doctor indicated further tests would be necessary and Anne was admitted to the Childrens Ward for a proposed oesophagoscopy later in the evening.

Pre-operatively a written consent for oesophagoscopy was obtained from Annes mother and one hour prior to surgery Anne was given a premedication IM Omnopon 8 mgms and Scopolamine 0.16 mgms.

The test was performed under a general anaesthetic and no foreign body was found. The surgeon reported that the oesophagus was "normal up to the cardia"

In the recovery room Annes observations were recorded half hourly and she had an uneventful recovery from the anaesthetic. When fully conscious she was returned to the Childrens Ward.

Her post-operative orders included Pethidine 40mg for pain and she was to have nil orally till the morning when strict fluids were to be introduced: She slept poorly that night and had four episodes of vomiting small amounts of bile stained fluid. The night staff recorded "that she seems cheerful with an occasional cough".

The following day Anne was seen by the surgeon and she was discharged home in her mothers care.

Four days later she was readmitted to the hospital in her town with the provisional diagnosis of Tracheitis following the history of having a pure stone caught in her throat.

Her admission observations were T 36.5 P120 R26 and she was reported to be apprehensive and pale, As well she had a "choking" sensation and a "harsh croupy cough at times".

The medical officer who examined Anne ordered the following medications. Ampicillin 250 mgms / 5mls Q.I.D, ~~and~~ Phenergan Cough Linctus P.R.N and the morphine was ordered insitu. That evening her temperature was 37^{3}C and she complained of a tickling sensation in her throat. By the next morning however Anne was afebrile - her throat was not sore and she was not coughing and consequently she was again discharged home c a script for a course of oral Ampicillin.

Within another four days Anne was back in the same hospital this time with a diagnosis of "chest infection". She was afebrile with a pulse rate of 152, respirations 24 and BP $\frac{115}{65}$. The doctor who saw her at the time recommended Ampicillin 250 mgms O.T.D.S and Benedryl Expectorant 5 mls O.T.D.S. Anne had been admitted at 2155 hours and for the remainder of the night she slept soundly in the childrens ward.

In the morning a chest X-Ray was done. Anne was afebrile however she had a moist cough

and was reported to be extremely apprehensive. In spite of this the child ate a full diet and took fluids well. Later on in the afternoon Anne had a "spasm" of coughing and began to scream uncontrollably – she felt she was unable to breathe. This feeling passed and Anne settled down with much support from the nursing staff. Her colour was good and she was given tinctus codeine for a tickle in her throat.

The report from the X-Ray taken in the morning showed "The heart size is normal. There is no definite area of consolidation visible in the lung field, which appears clear, and no evidence of an obstructed segment is seen"

Over the next five days Anne remained afebrile and had no further episodes of not being able to breathe and so she was again discharged home with a script for Ampicillin and an appointment to see her doctor in one weeks time.

According to Annes father, over the next few weeks, his daughter lost weight, and days at school, because she had "episodes of not breathing". He maintains he could hear a "click" when Anne breathed and he said it reminded him of a valve shutting down. Annes parents became more concerned about her general well-being and following discussion with their doctor Anne was refered to a city specialist, and subsequently readmitted to hospital for a Bronchoscopy.

On admission Annes observations were T 38^{5} P90 R24. The medical officer on duty examined the child and found she had very little movement of her left chest, and that there was a marked decrease in air entry to the left side of her chest. He ordered Panadol 5 mls Orally, 4 hourly PRN to bring down her temperature.

Anne settled well into the ward and was seen by the Anaesthetist who ordered a

premedication of Omnopon 15 mgms Scopolamine 0.3μ mgms to be given at 1300 hours the following day. Anne was to have an early breakfast and fast from 0800 hours ~~for~~ in preparation for the Bronchoscopy.

The procedure had been explained to Anne and her parents who also signed a Form of Consent for their daughter to undergo the anaesthetic and that particular operative procedure.

On the morning of her operation day (and after breakfast) Anne complained of a sore throat and stomach ache and later vomited her breakfast. Her temperature was 38.5°C pulse 140 and respirations 38.

The anaesthetist was notified and after he examined Anne he certified her not fit for a general anaesthetic. Blood tests were ordered and an urgent chest X-Ray was taken: Her observations at 1315 hours had altered to T 39.2 P160 R28.

Anne remained in bed feeling generally very miserable and tolerating only small amounts of clear fluids. She was commenced on IM Gentamycin 60 mgms 8 hourly ~~with the first dose~~

The next day her chest X-Ray showed bronchopneumonic collapse and consolidation of her left lower lobe. The right lungfield was clear, heart size normal while the mediastinum had shifted slightly towards the left. Annes W.C.C was 16,800.

Within two days Anne was up and about the ward. Her diet and fluids were increasing and although she had a cough at times, she remained afebrile. A further chest X-Ray ~~on 30th~~ showed that considerable clearing of her left lower lobe had occurred.

Sputum was collected for M&C. The culture grew Staph aureus and mixed flora sensitive to Amoxycillin and Tetracycline and so Annes medication was changed to Amoxil ~~250 mgms~~ 250 mgms 0

Over a period of days Anne's general condition improved suitably enough for the bronchoscopy to proceed. At this examination which was done under a general anaesthetic a prune stone was recovered from her left lower bronchus. The child made an uneventful recovery from the anaesthetic and returned conscious to the ward.

In another two days, following chest physiotherapy and the antibiotic therapy a further chest x-ray showed almost complete clearing of Anne's lung had occurred. She still had a moist cough and expectorated a small amount of rust coloured sputum.

Anne was in much better spirits - was eating, drinking and voiding well and so, after a final examination by the doctor in charge of her treatment at that particular time she was discharged home. Almost 2 weeks had elapsed since the day she had prunes for lunch and was unfortunate enough to have one prune stone retained in her air passage: