A WANDERING SPRAY NOZZLE

A Case Report

BY

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SUMMARY

A case is described where a metal nozzle from a lignocaine spray bottle became detached at laryngoscopy, passing unnoticed into the pharynx and oesophagus. It was subsequently recovered at laparotomy from the patient's large bowel where its further progress had been arrested by an obstruction at this site.

A patient aged 44 years, attended in the Out-Patients Department with a history of tiredness, loss of weight, anorexia and looseness of the bowels, of three months duration. On examination she was clinically anaemic, and a hard irregular mass arising out of the pelvis was palpated. A barium enema examination showed a defect in the sigmoid colon which was "irregular in shape and with a narrow lumen; consistent with a diagnosis of carcinoma".

A week later she was admitted to hospital because of pneumaturia and faecuria. Two days later sigmoidoscopy, cystoscopy, and transverse colostomy were performed under general anaesthesia. A large mass involving the uterus, sigmoid colon, and bladder was demonstrated. Details of the anaesthetic given were recorded as follows: thiopentone (2½ per cent) 350 mg; suxamethonium 50 mg; larynx sprayed with 4 per cent lignocaine, using Astra-Hewlett spray bottle; 9 mm cuffed oral endotracheal tube; spontaneous respiration with nitrous oxide, oxygen and halothane (VOC) during sigmoidoscopy and cystoscopy; intermittent suxamethonium, nitrous oxide and oxygen, IPPV during colostomy. The postoperative course was uneventful.

Ten days later the patient was anaesthetized for formal resection of the pelvic lesion. During the operation a hard, thin, apparently metallic object was palpated by the surgeon in the colon, just proximal to the sigmoid colon which was involved in the pelvic mass. Examination of a plain radiograph of the abdomen taken after the first operation revealed a corresponding shadow (fig. 1). This was readily apparent, but previously its significance had not been appreciated. It was no doubt assumed to form part of the metallic buckle on the strap holding the patient's colostomy bag in position. The pelvic mass was resected, and on opening the colon the object removed was found to be a nozzle from a spray bottle of Xylocaine (fig. 2). The radiograph (barium enema) taken before the colostomy was performed did not show this shadow.

The inference, therefore, is that the nozzle must have dropped off the lignocaine spray container into the patient's pharynx at the time of the first anaesthetic, during or immediately after the spraying of the larynx. It seems surprising that this could happen unnoticed by the anaesthetist. However, when putting the spray bottle aside one's vision is usually kept focused on the larynx preparatory to passing the endotracheal tube. Also it is possible that the fine spray could tem-
porarily obscure the presence of a foreign body in the pharynx. The nozzle having entered the pharynx must have passed into the oesophagus and subsequently made its way along the gut to the sigmoid colon where its journey was arrested by the bowel obstruction. Although no serious consequence occurred in this instance, there is obviously a potential danger in the use of this particular piece of equipment. Awareness of this hazard should, however, obviate its recurrence.

Bowen (1966) recently drew attention to a similar potential hazard from the use of the Rogers laryngeal spray. The author has recently had the experience of observing the atomizer button of a Macintosh spray separate from the end of the spray tube whilst spraying the trachea. Fortunately it was recovered without difficulty at bronchoscopy.

ADDENDUM
Since the occurrence reported in this article the manufacturers, Messrs. Astra-Hewlett Ltd., have modified their spray by permanently fixing the nozzle to the actuator valve. This should obviate a further mishap although, of course, the hazard will exist while the original sprays from existing stocks are still in use.

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REFERENCE

UN AJUTAGE DE VAPOURISATEUR EN PROMENADE

SOMMAIRE
On décrit le cas d'un ajutage métallique d'un flacon vaporisateur de lignocaine qui s'est détaché durant une laryngoscopie et s'est faufilé de manière inaperçue dans le pharynx et l'oesophage. Plus tard, il a été retrouvé lors d'une laparotomie dans le gros intestin, où sa progression avait été arrêtée par une obstruction locale.

EINE WANDERnde ZERSTAUBERDÜSE

ZUSAMMENFASSUNG
Es wird ein Fall beschrieben, bei dem sich während der Laryngoskopie die Metalldüse eines Lignocainzerstäubers löste und unbemerkt den Pharynx und den Ösophagus passierte. Sie wurde später bei der Laparotomie im Dickdarm des Patienten gefunden. Wegen eines Hindernisses an dieser Stelle war sie an der weiteren Fortbewegung gehindert worden.