

**REPORT OF A CASE OF REMOVAL OF A FOREIGN BODY,  
A GRAIN OF CORN, FROM THE TRACHEA OF  
A CHILD SIX YEARS OLD.\***

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The following is a short account of a successful case of the removal of a foreign body from the trachea of a child by tracheotomy, after an unsuccessful attempt at tracheoscopy had been made.

Paul B., aged 6 years, was admitted to the Episcopal Eye, Ear and Throat Hospital January 22d, 1908, giving the following history:

Several days before his admission to the hospital he was playing horse, and while in the act of munching corn from the cob, a large grain was drawn through the larynx into the trachea. He was seized with violent coughing and dyspnea; but he soon quieted down to such an extent that when his family physician examined him he could not find any difficulty with the breathing, and concluded that the grain of corn had not passed into the trachea. During the night, however, he was seized with several very severe attacks of dyspnea and coughing, which continued through the following day, when the breathing became quiet again. He was then brought to Washington and admitted to my service in the Eye, Ear and Throat Hospital January 22d.

On admission, I made a careful examination of the child, and found him suffering from a large hypertrophy of the post-nasal lymphoid tissue and hypertrophy of the faucial tonsils. His color was natural, his voice thick and somewhat husky, which could be accounted for by the enlarged tonsils and the adenoid. The respirations were somewhat quickened, but not more so than one would expect in a timid child when in the presence of strangers. Auscultation showed large and small mucous rales over both sides of the chest anteriorly and posteriorly. The air apparently entered the lungs freely.

An X-ray picture was made, but it did not reveal the presence of a foreign body in the air passages. He was kept in the hospital under close observation for three days, but as no dyspnea was ob-

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served in this time he was allowed to return to his home in Maryland.

On the morning of January 30th, he returned to the hospital suffering from intense dyspnea and marked cyanosis. An examination of the lungs at this time showed a complete absence of the respiratory sounds on the right side, while mucous rales were heard on the left side both anteriorly and posteriorly. When I saw him about two and a half hours after his admission, these physical signs had completely changed. The air was found to be passing freely into all parts of the lungs. He was still breathing with great difficulty and complaining of intense pain in the subglottic region. Evidently the foreign body which had been engaged in the large bronchus on the right side had been dislodged and had been carried into the upper part of the trachea, where it was caught by the swollen mucous membrane.

I had him sent to the operating room, and placed under chloroform anesthesia with the view of trying to remove the body through a Killian tracheal tube. I made several ineffectual efforts to pass the small tube through the larynx, but owing to the swollen condition of the mucous membrane lining the larynx, I found this was impossible; just at that moment the child ceased to breathe and became very cyanotic. I then did a rapid tracheotomy, expecting to pass the tube through the tracheal opening and remove the foreign body in this way. As soon as the trachea was opened the child commenced to breathe freely again, a grain of corn was seen to pass the tracheal opening on its way to the lower trachea. It made several such excursions before I was able to grasp it with my forceps and remove it. A tracheotomy tube was then introduced into the tracheal opening. He rallied quickly from the operation, and as all obstruction to the respiration ceased after the removal of the foreign body he was sent to his bed.

When the grain of corn was removed it was found to be an unusually large one, and very much swollen from the moisture absorbed since its introduction into the trachea.

The tracheotomy tube was removed on the fourth day, and the wound allowed to close. Some laryngeal stridor remained for at least twenty-four hours longer, when it ceased. The patient made an uninterrupted recovery, and was discharged from the hospital on the ninth day.

This case is interesting, and shows it is not always best to persist in passing the Killian tube through a swollen larynx after several ineffectual attempts have been made. Had I continued my efforts to reach the trachea in this way, I am sure I would have done irreparable injury to the soft parts, and had I succeeded in introducing the tube through the larynx it would have been impossible to remove a grain of corn of this size through the tube, but with a large tube introduced through a tracheal opening I might have been able to reach the foreign body and remove it. Fortunately the introduction of the tube through the tracheal opening in this case was not necessary, as the above history shows.

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**Critical Remarks upon Empyema of the Saccus Endolymphaticus, and the Importance of the Aqueductus Vestibuli as a Path of Infection.** OSCAR WAGENER. *Archiv für Ohrenheilkunde*, July 1906.

The author reports a case of cerebellar abscess, in which the abscess was adherent to the posterior surface of the petrous portion of the temporal bone, in the neighborhood of the opening of the aqueduct of the vestibule. Careful microscopical examination revealed the fact that the abscess was caused by perforation of a bone abscess through the dura. The dura was infiltrated with pus, but it could be clearly seen that the saccus endolymphaticus was free from pus, although surrounded by infiltration. The aqueduct was also free from exudate.

In all the cases reported in the literature, in which it was claimed that infection had travelled from the labyrinth through the aqueduct and sac to the cerebellum, the author could find only one case in which microscopical examination showed the presence of pus in the sac and aqueduct, the case of Pollitzer; and the author is inclined to agree with the latter in the view that such a mode of infection is an unusual one. The infection generally travels by direct extension through the bone.

YANKAUER.