Expecoration of Foreign Body Lodged in Bronchus for 27 Years*

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A case is presented of a foreign body being expectorated after having been lodged in the bronchus for 27 years. The presence of the foreign body was not recognized and this cause for his pulmonary disease was never considered seriously during his prolonged illness. After the foreign body was recovered, he was re-examined roentgenographically and his previous chest roentgenograms were reviewed. The foreign body can be recognized on the films taken early in this illness dated October 3, 1942 (Figure 1). It can be visualized again on the more recent films taken July 13, 1954 (Figure 2). This illness is of interest because its etiology was unrecognized, although he was examined by many competent specialists in diseases of the chest and radiologists during his prolonged illness.

Case Report

The patient was first seen July 17, 1953 at the age of 44. He came to the office to be treated for an acute respiratory infection. For two days, he had had a cough productive of yellow sputum and was febrile. His temperature was 101 degrees. There was decreased expansion of the left chest and the left hemithorax was smaller than the right. The trachea was deviated to the left. There was marked diminution in breath sounds over the left chest and dullness in the same area. These changes were more marked in the lower half of the left chest. Voice sounds were equal bilaterally. The heart and mediastinum were deviated to the left. An apical diastolic gallop was

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present. The heart rate was 100 per minute. He refused a chest roentgenogram at that time because so many had been taken previously and he did not wish to have a comprehensive re-evaluation of his problem. At that time, he was given tetracycline, syrup of hydriodic acid, and advised to use postural drainage.

Regarding his past respiratory history, he dated his difficulty from 1931 when he developed a cold and had intermittent fever and malaise for approximately a six-month period. When examined by his physician in the fall of 1931, he was told that his difficulty was asthma and hospitalization was advised for further evaluation. Empyema of the left chest was diagnosed and treated with open drainage. The wound continued to drain for four months. At that time a thoracoplasty was advised, but refused. He was unable to work for the following 18 months because of weakness and malaise. There was some improvement, but he never regained his usual state of health.

He was able to do light work. In June of 1942, he developed pneumonia and was hospitalized in a tuberculosis sanitarium with the provisional diagnosis of pulmonary tuberculosis. He was told that his sputum examinations were negative in the sanitarium, and he left the sanitarium against advice when moved into a room with a positive sputum patient. He was re-hospitalized in September of 1942. After bronchoscopy, pneumonectomy was advised for bronchiectasis of the left lung. Other doctors attending him at that time advised against this procedure and it was not performed.

Again, he was able to return to light work. In 1951, because of increasing symptoms of pulmonary insufficiency and back pain, he left his home in Michigan and moved to New Mexico, later to Arizona, then California, and finally to Colorado. These moves were made in an effort to find a climate which might improve his health. During this interval of time, he had acute respiratory infections which were treated with sulfonamides, penicillin, and tetracycline.

He was seen again in our clinic a year following his initial visit with the symptoms of rapid heart action, increasing dyspnea, and nocturnal dyspnea. At that time, there was increased distention of neck veins and slight liver enlargement. The physical findings pertaining to the chest were unchanged. It was our opinion at that time that he was developing cor pulmonale with mild right sided failure secondary to his pulmonary disease. On that visit, our first chest roentgenogram was obtained which is shown in Figure 2.

The patient was digitalized, given ephedrine, and instructed in a low sodium diet.

In March of 1955, he returned to the office complaining of bloody sputum and fever and increasing difficulty in breathing. In July of 1955, he complained of severe
backache in the lower dorsal area which was believed due to the spinal deformity with nerve root irritation secondary to his adhesive pleuritis. On February 7, 1956, he was showing some signs of clubbing of the fingers, but none of the toes.

In August of 1957, the patient was awakened with a severe coughing episode during which he felt an object in his mouth. He removed the object and recognized it as the cervical vertebra of a rabbit (Figure 3). On seeing this, he recalled having eaten rabbit pie in 1930 (approximately three months before the onset of his pulmonary symptoms). While eating the pie, something stuck in his throat, which he thought at the time was a rabbit bone. He took mustard water to induce vomiting. After vomiting profusely, he felt relieved and assumed the bone was in the vomitus. Not until this time did he relate the rabbit bone to his prolonged pulmonary disease. None of the many doctors who had examined him during his illness had questioned him regarding the possibility of aspirating a foreign body. Figure 4 shows a chest film following expectoration of the rabbit bone. On comparing this film with the film of the bone and the previous films, the foreign body can be recognized just above the anterior end of the left third rib.

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USE OF NITROUS OXIDE WITH OXYGEN IN PAROXYSMS OF BRONCHIAL ASTHMA

A portable anesthesia apparatus was used for the administration of the gas mixture. The treatment was instituted 137 times in 108 patients suffering from bronchial asthma. Lasting effect was attained in 119 cases; a short-term improvement occurred in 12 and in six cases, the therapy was ineffective. The above mixture is particularly indicated when bronchial asthma is coupled with stenocardia. No complications were observed.


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ON THE FACILITATION OF ANATOMO-FUNCTIONAL SUBSTITUTION OF THE LUNG

Monaldi and Fioretti state that in cases with bronchopulmonary malformations, the diseased lung and the mediastinum may represent an obstacle to anatomofunctional substitution and compensation by the sound lung on the opposite side. They carried out experiments on puppies, subjecting them to pneumonectomy with a large opening of the posterior-inferior and anterior-superior mediastinum. Two to three months after the intervention, radiologic, bronchographic, angio-pneumographic investigations and post-mortem findings showed that segmental branches of the superior and inferior lobe shifted to the opposite hemithorax in order to fill up the residual space of pneumonectomy.