

Letter to the Editor

Foreign Bodies in Thyroid Gland

I read with interest the report by Muhanna *et al.* (1990) regarding lodgement of a fish bone in the left thyroid lobe. The authors stated that they had found no similar cases of thyroid lodgement reported in the literature.

Three instances of foreign bodies consisting of two chicken bones and one fish bone lodging in the thyroid lobe resulting in intra thyroid abscess had been described four decades earlier (Jemerin and Aronoff 1949). Following foreign body perforation of the cervical oesophagus, infection was confined to the thyroid lobe in two instances and associated with a retrooesophageal abscess in the third. Differing perforation sites and migration patterns of the foreign body probably accounted for these different modes of presentation. Lateral or anterolateral perforation with direct entry of the foreign body into the corresponding thyroid lobe resulted in effects limited to the gland. In contrast, posterior or posterolateral perforation into the retrooesophageal space and subsequent migration of foreign body anteriorly into the thyroid lobe could conceivably account for both retrooesophageal and intrathyroid abscess.

The scenario of multiple repeated negative oesophagoscopies and even repeated neck explorations was a striking feature in the management of these cases. This situation could have been avoided with the appropriate use of computed tomography scans which was of course not available in the 1940s. Lydiatt *et al.* (1981) had stated that computed tomography is the best radiological modality available in the evaluation of penetrating injuries to the soft tissues. With its use, a precise pre-operative localization of the foreign body is achieved as elegantly illustrated by the computed tomography picture provided by Muhanna *et al.* (1990). This information avoids the need for unrewarding repeat oesophagoscopies with its potential for attendant complications and aids the surgical external approach used.

It is suggested that a CT scan of the neck is a most helpful investigation if an external approach is contemplated following negative oesophagoscopy findings performed by a competent operator and persistent visible foreign body opacity on lateral cervical radiograph.

Still on the topic of foreign body migration into the thyroid gland, it is worth mentioning that the other well known and

more frequently reported phenomenon is that of Polytef migration into the thyroid lobe following laryngeal injections. It is a slow process occurring over months and tends to induce a subacute or chronic inflammatory response resulting in foreign body granuloma rather than causing an abscess as happened in all the above cases. It has been known to mimic a cold thyroid nodule or even carcinoma of the thyroid (Walsh and Castelli 1975, Stephens *et al.* 1976, Sanfilippo *et al.* 1980).

I would be grateful if you could bring these comments to the attention of your readers.

Yours faithfully,

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The original authors have been invited to reply but as they live in Kuwait, this sadly poses obvious problems both postal and otherwise. Editor.