

## MISSING OPPORTUNITIES TO DIAGNOSE CERVICAL SPONDYLODISCITIS AFTER BATTERY INGESTION

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**Aim:** To persuade surgeons to perform an MRI on all children with longstanding oesophageal battery impaction.

**Methods:** We describe a 2 year old presenting with 7 days history of button battery ingestion and dysphagia. During initial battery retrieval, an 8cm posterior stripe of sloughing erythematous mucosa was seen in the proximal oesophagus. Neither obvious perforation or fistulation was seen at oesophagoscopy or X-ray; nor was there any unusual excrescence emerging from the posterior wall. He recovered well, and was discharged the following day, swallowing liquids uneventfully. But 5 weeks later, he re-presented with recurrent fevers and shoulder girdle pain. There was no dysphagia. Oesophagoscopy demonstrated a 5cm polypoid mass extending to occlude about 50% of the oesophageal lumen in the region of the previous erythema.

**Results:** CT and MRI scans revealed thickening of the pre- and paravertebral soft tissues; and partial destruction of the anterior aspects of T1/T2 with associated involvement of the T1/T2 & T2/T3 discs. The child was fit for discharge home the day afterwards, with a cervical collar for comfort and 6 weeks of intravenous antibiotics. Two weeks later the polypoid mass had significantly improved at elective oesophagoscopy, reassuring us and mother that the treatment was working. It has since disappeared.

**Conclusion:** Late presentation of spondylodiscitis after battery ingestion is described, but we took false reassurance from endoscopy, plain radiology and normal swallowing that there was no perforation.

In hindsight, the symptoms from the shoulder girdle alone, in a child with a long history of impaction should have prompted the MRI, since they hinted at the spinal columnar infection. But at an earlier stage, if surgeons encounter a polypoid mass in these circumstances, this case may remind them to consider an occult oesophageal perforation, and associated spondylodiscitis.