The Editor:

Prof. Foster is correct – ideas do change. It appears, however, that belief in supernatural phenomena such as clairvoyance and things that go bump in the night do not. He is also correct in regarding an open mind as a prerequisite – but this does not entail abandoning one’s critical faculties. Indeed, critical examination of the relevant sources quoted by Prof. Foster shows either outright fraud, gullible “researchers”, wishful thinking or all three and arguments about not being able to think “outside the box” are beginning to sound rather tired.

It is interesting to note that Prof. Foster recommends a book by Antonio Damasio, but when confronted with evidence that this famous neuroscientist is not a Cartesian, it is called an “unsupported opinion” and not germane!

Prof. Foster seems to have misread or misunderstood large sections of my reply to his article and I will limit my response to this.

1) I did not “rip to shreds” Schwartz’s work – this was done by scientists eminently qualified to assess such “research” and the critique was not written before the results were published. Schwartz published his original research in *Journal of the Society for Psychical Research* in 2001 and the critique by Wiseman and O’Keefe and James Randi appeared later that year. Schwartz widely trumpeted this “research” but his “protocol” for subsequent experiments was as inadequate as the original. His experimental subjects were well-known charlatans such as John Edward and George Anderson – “mediums” who pretend to speak to the dead and who rip millions off grieving people aching to hear from their departed relatives. These “mediums” are well versed in bamboozling experimenters who, to begin with, are all too willing to believe in such supernatural phenomena.

2) Prof. Foster surmises that the physicist Victor Stenger “must have published before the concept of p-branes became accepted”. Stenger has published many papers on this theory.

3) I did not “dogmatically” debunk an application of string theory by an acknowledged leader in the field (Who? No reference is given) and I am well aware of its status in the physics community. I merely repeated what even popular books on string theory and quantum physics tell us: that the postulated extra dimensions exist only on a subatomic scale. Beings (if any) who inhabit these dimensions must quite clearly be as small as the dimensions in which they reside. No amount of obfuscating tap-dancing can sidestep this fact. It is therefore not my last paragraph which is confused, merely Prof. Foster’s reading of it. The question stands: how many angels can dance on the head of a pin?

4) I am not *au fait* with all research emanating from the Buddhist Mind-Life Institute, but what I am familiar with – e.g. the neurobiology of meditation – is firmly within the boundaries of good science.

5) Stephen Hawking (not Stephan Hawkins) did indeed show that yesterday’s heresy may be tomorrow’s commonplace, as did many other authors. However, even more scientific heresies have deservedly vanished without a trace. To be a new Galileo one must not only be contrary, one must also be right. Trusting the notoriously unreliable human memory and putting faith in known charlatans is hardly the way to do science.

LW Retief
Bellville

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**A case report:** accidental removal of laryngeal foreign body along with the tracheal tube

**The Editor:**

**SUMMARY**

Foreign body aspiration is a common problem in children. Laryngeal impaction is a life-threatening event and may cause total airway obstruction. The spectrum of presentation varies widely, from sudden death to an accidental finding during routine investigations. A case is reported where the patient did not have typical symptoms and signs of foreign body aspiration, and presented with only a loss of voice. It was removed in an unusual way accidently, after a negative bronchoscopy.

**INTRODUCTION**

Most foreign body aspirations occur in patients younger than 15 years of age. The maximum incidence is between the ages of 1 to 3 years. It is due to the natural urge to explore and insert objects into the mouth or to chew on something during teething. It may occur whilst the child is crying, or playing whilst eating, and often when there is lack of parental supervision. Older patients may have an anatomic abnormality or neurological impairment. Foreign bodies lodge in the larynx if they are too large to pass through, are of irregular shape or have sharp edges, which may catch on the laryngeal mucosa. They consist of food...
An eight-year old male child was playing with a plastic toy, which he suddenly put in his mouth. According to the attendants, he was chewing on it. They gave a history of a violent cough at the time of incident. After that, the child was unable to speak, but there was no respiratory distress. On examination, vital signs were stable, and bilateral air entry was equal. Chest X-ray revealed no changes such as atelectasis or air trapping, and blood gas analysis (BGA) revealed a normal PaO2. A probable diagnosis of foreign body aspiration was made and bronchoscopy was planned. After placing routine monitoring on the child, atropine 0.02mg/kg was given intravenously. The child was induced with propofol 2mg/kg, fentanyl 2 g/kg and paralyzed with atracurium 5mg/kg. Once the child was apneic, the surgeons introduced a size 4 bronchoscope. Anaesthesia was maintained with oxygen in sevoflurane. A thorough endoscopy of the trachea and bronchi did not reveal any foreign body. The bronchoscope was then removed, and the child intubated with a 6 mm cuffed endotracheal tube. Residual effects of the muscle relaxant were reversed with intravenous neostigmine and glycopyrrolate, and his trachea was extubated when he was fully awake. To our surprise, the foreign body came out encircling the tube at its lower end (Fig. I). It was a broken part of a transparent red plastic toy, which was hollow and tubular in shape, and open on both sides.

Most foreign bodies in the airway become lodged in the bronchi because their size and configuration allows their passage through the larynx. Laryngeal impaction of a foreign body is very rare but is dangerous, in that it has potential for sudden airway obstruction. Foreign bodies can settle in the hypopharynx (5%), larynx (2-9%), trachea (12%) or bronchus (83%).2 Patients may present with hoarseness, cough, stridor, wheezing, cyanosis, aphonia or a subjective feeling of the foreign body.3 Aphonia may suggest total obstruction of the larynx.4 Our patient demonstrated aphonia, but no obstruction.

It is usually possible to diagnose the presence of a foreign body in the airway in the acute phase of entry because of a readily available history.5 It is remarkable that our patient did not have any respiratory distress, despite the presence of a large foreign body in the upper airway. Tracheobronchial foreign bodies can sometimes be very difficult to remove. This may be related to the location of the foreign body and the experience of the bronchoscopist.6

Foreign bodies have been removed in different ways in the literature, but we could not find any accidental removal as in our case. Kamsara et al reported an unusual laryngeal foreign body (sticker) with a rare presentation of just loss of voice.8 A case has also been described in whom an impacted tooth could not be removed from the bronchiolo of a ventilated, critically ill patient using rigid and flexible bronchoscopy, and a radiological approach was used to remove it.9

Masood et al reported the unusual method of removal of an artificial denture: accidental lodged in the trachea of an adult female after a caesarean section. Removal was done via a tracheostomy, using a rigid bronchoscope and forceps.10 Leffler reported the removal of a foreign body in a 6-year old child, by turning him upside-down by his feet, and used a laryngoscope.

However, in their case the object was large and dense.11 Fung et al reported the removal of an aspirated prosthetic tooth by tracheal backflow of air. It had been difficult to remove with routine bronchoscopy, and was removed by deflating the endotracheal tube cuff and at the same time compressing the ambu bag. The foreign body was dislodged by an upward flow of air.12

Irregular foreign bodies may produce only partial obstruction, allowing adequate air movement around the obstruction. In our patient, the toy was hollow and tubular in shape and lying vertically, so did not cause respiratory distress but hampered the patient’s phonation. The open ends on both sides of the foreign body allowed free passage of both the bronchoscope and tracheal tube. The tubular shape allowed the passage of air, explaining the negative respiratory findings. It was missed by the surgeons as it was transparent, and its colour matched with that of the laryngeal mucosa. It was also abutting the internal circumference of the airway. It did not stick to the bronchoscope, but instead came out with the tracheal tube. This could be explained on the basis of the greater outer diameter of a size 6 mm tube (OD-6 mm) as compared with the size 4 bronchoscope (OD-6.7 mm).

It is suggested that a much closer direct laryngoscopic examination be done, so as not to miss these types of foreign bodies.

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