Foreign-body aspiration in an adult

I have read the manuscript "Foreign-body aspiration in an adult" by Qureshi and colleagues,[1] and I congratulate the authors on their successful treatment of such a rare case. Yet, I want to remark on some aspects of the manuscript.

In the discussion section, the study by Baharloo and colleagues[2] is referenced as stating, "In the adult population, such aspiration is most commonly secondary to unconscious accidental ingestion during general anesthesia, sedation, intoxication, seizures or neurologic disorders affecting the oropharynx." However, such information is not included in the above-mentioned manuscript. In this retrospective study,[2] 28 adult patients were examined, and no debilitating factor predisposing to foreign-body aspiration was encountered in any of these patients. In addition, the authors found that the foreign-body aspiration resulting from dental surgery accidents is more common in adults. As a result, they indicated that foreign-body aspiration can occur in the absence of any predisposing factor.

In fact, the factors predisposing to foreign-body aspiration and the type of aspirated object are affected by geographic and cultural differences. Throughout the world, the types and aspiration ratios of aspirated foreign bodies change according to nutrition habits, socioeconomic status, culture and the traditions and customs of the people. Still, serious changes have been observed both in the incidence of predisposing factors and in the nature of foreign bodies aspired. In the last decade, we have encountered an increasing number of cases of turban pin aspiration. The increase in the number of women in Turkey and the Middle East who wear turbans increased the aspiration frequency of pins used for securing the turbans. During the fixation of the turban, the neck is extended and the pins are held between the lips. Speech or laughter can cause the deep aspiration of the pin into the tracheobronchial system. A comprehensive study carried out in Turkey showed that the most common aspired foreign body is the turban pin, which is in keeping with our experiences.[3]

Many comprehensive studies have determined the characteristics and ratios of predisposing factors for foreign-body aspiration in adults. Limper and colleagues[4] determined that impairment of protective airway mechanisms occurred in 25 of 60 cases of adults who aspired foreign objects. Lan[5] studied 47 adult patients with nonasphyxiating tracheobronchial foreign bodies and divided them into 4 groups (acute, chronic, uncertain and broncholith) according to the duration of foreign-body aspiration. Of the 29 patients in the chronic group, mechanical ventilation was started in 1 patient who was comatose due to sepsis, and another patient had a seizure after aspiring a foreign object. In the other cases, predisposing factors such as neuromuscular or swallowing disorders, or abuse of alcohol and/or sedatives were not determined. Lai and colleauges[6] determined predisposing factors in only 6 patients in their series of 40 cases. In a study by Debeljak and colleauges[7] in Slovenia, 62 adults were examined, and it was found that the most common foreign object aspired was pieces of bone. There were no neurologic disorders or loss of consciousness in any of these patients. In the study by Zubairi and colleauges,[8] 4 adult cases of foreign-body aspiration were presented and no risk factors were determined. Finally, as the results of these studies are taken into account, it seems that many cases of foreign-body aspiration may occur without predisposing factors.

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Competing interests: None declared.

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(Dr. Behzadi replies)

It is with pleasure that we see our case report[1] in the *Canadian Journal of Surgery* (*CJS*) has generated considerable interest. We thank Dr. Karapolat for an informative letter.

The diagnosis of foreign-body aspiration (FBA) in adults, which includes the geriatric population, is perhaps underreported. To truly determine the incidence of FBA in adults and identify the predisposing factors, one needs to include the examination of the records of patients who did not survive the occurrence. Aspiration pneumonia is a common and often terminal event in debilitated patients and is encountered frequently at autopsy.[2] Moreover, patients in whom complications of overlooked FBA develop should also be included in any analysis. A study of 59 cases of foreign-body aspiration diagnosed on biopsy or resection specimens[3] showed the presence of predisposing factors in most patients. Therefore, any conclusion on the incidence of predisposing factors based on the outcomes of alert and oriented patients who seek medical care after a suspected FBA such as a turban pin aspiration should be viewed with caution.

In our discussion, the reference to Baharloo and colleagues[4] should have mentioned the lack of identifiable predisposing factors in some cohorts while emphasizing the known risk factors for FBA such as impairment of protective airway mechanisms.[5]

The objective of our case report for the general readership of *CJS* was mainly to demonstrate that the aspiration of a large object in an adult could potentially be tolerated for an extended period of time, and that the management of such a problem can be quite challenging.

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Competing interests: None declared.

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Codes of professionalism and ethics

I was interested to read the "Code of professionalism"[1] in the April issue of the journal. I see no mention of continuity of care, itinerant surgery or itinerant patients. As such, I think the document is inadequate. I am not sure why the Canadian Association of General Surgeons should require a document separate and distinct from the "Code of Ethics" published by the Canadian Medical Association.[2] Perhaps that document needs to be reworked to include timely issues of technology and research.

Finally, I think that our professionalism is more serious than a game of cards. I agree that "doing right by the patient will always trump the business or pecuniary interest of the surgeon." I am not sure the language is appropriate to the document.

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(Dr. Bond replies)

We thank Dr. Driedger for his interest in our article[1] and we shall try to address his concerns one by one.

With regard to his concerns that the code of professionalism needs to be more comprehensive, we would submit that the code has to deal with guiding principles and overarching standards and therefore cannot address each and every instance of conduct in which the surgeon must or must not engage. Nevertheless, we thank Dr. Driedger for pointing out that continuity of care and itinerant surgery must also be carried out in keeping with the code of professionalism.

With regard to his view that the document is unnecessary in view of the already published "Code of Ethics" of the Canadian Medical Association, the reasons and rationale for the Canadian Association of General Surgeons (CAGS) and our committee to take a renewed and deep interest in the subject of professionalism for surgeons is laid out in the article itself, in its first few paragraphs. In this respect, CAGS is not alone in producing its own code of professionalism to guide its members; the American College of Surgeons and the American Academy of Orthopedic Surgeons each have their own codes of professionalism (referenced in the article).

Finally, Dr. Driedger seems not to agree with use of the word "trump" in the code itself. In fact the word has both solemn legal usage and usage in a serious medical context. As an example of the former, we would point to its repeated use in the constitutional law jurisdictions of the principles enshrined in the Charter of Rights and Freedoms "trumping" other laws. And as an example of the latter, we would point out that the *Oxford Dictionary of American English* includes the following definition of the word "trump": "beat someone or something by doing or saying something better." And the same dictionary goes on to give the following usage example: "if the fetus is human life, that trumps any argument about the freedom of the mother."

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