of large joints. Clubbing has been associated with various gastrointestinal disorders like inflammatory bowel disease, sprue, and bowel neoplasms. It has also been rarely associated with esophageal carcinoma, Plummer-Vinson syndrome and achalasia cardia. There is only one earlier report of its association with corrosive stricture of esophagus.

An 18-year-old girl presented with history of dysphagia three months following ingestion of formic acid. She had noticed pain and progressive enlargement of all her digits about one month after ingestion of the corrosive. Clinical examination revealed grade IV clubbing of all digits of both hands and feet (Fig). The patient did not have cyanosis and had no evidence of cardiac disease, lung disease, inflammatory bowel disease, or any connective tissue disorder. No other family member had this finding. Cardiac and respiratory systems were normal.

Investigations: hemoglobin 12.6 g/dL, WBC 6400/mm³ and ESR 14 mm in 1st hour. Liver and renal function tests were normal. Echocardiography and radiography of the chest revealed no abnormalities. X-rays of hand and foot showed periosteal elevation characteristic of HOA (Fig, inset). Barium swallow revealed stricture in the mid esophagus with proximal dilatation. Upper GI endoscopy showed a stricture in the middle third of esophagus.

She underwent five sessions of dilatation using Savary-Gilliard dilators. The patient had relief of dysphagia and gradual regression of clubbing after 9 months.

The exact mechanism of clubbing is unknown. The theory that stimulation of vagal neural arc is an etiological factor is supported by reversal of the syndrome after vagotomy. Recently various growth factors like fibroblast growth factor, hepatocyte growth factor, platelet-derived growth factor, and vascular endothelial growth factor have been proposed to play a role in the formation of digital clubbing.

Endoscopic management of esophageal bezoar in a child

Bezoars are very rare in the esophagus. We report a young child with esophageal bezoar who was managed endoscopically.

A 15-month-old male child was referred with complaints of vomiting and cough after intake of solid or semisolid food, for four months. The symptoms were progressive and for the last one month, the child had vomiting immediately after each meal. He had lost one Kg of weight. The child was delivered full term, normally, and weaning was started at the age of 6 months. On examination he was mildly malnourished; his weight was 7.5 Kg, height 78.7 cm. Milk intake and milestones were normal and systemic examination was unremarkable.

Hemogram, renal and liver function tests were within normal limits. Chest X-ray was normal. Barium swallow showed smooth narrowing at the lower third of the esophagus, and above this the esophagus was grossly dilated with multiple filling defects of varying size.

Upper GI endoscopy with forward-viewing video endoscope (GIF-V; Olympus, Tokyo, Japan) under conscious sedation showed dilated esophagus, filled with multiple brownish black semisolid material of size 0.5-2 cm. This consisted of multiple food particles including seeds and betel nut (Fig). These were removed by using a Roth retrieval basket (indigenously made; Endotech, Jaipur). After clearing the esophagus, a web was seen at 18 cm from the incisors, which was dilated with balloon dilator (MaxForce TTS; Boston Scientific, USA).
child was observed for 6 hours and then oral feed was started. One month later the child was asymptomatic.

Esophageal bezoar is managed by endoscopic removal or surgical intervention. In our case the child had a lower esophageal web that was dilated once and on follow up he was completely asymptomatic. We also describe the use of an indigenous retrieval basket.

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References

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