Failure to Thrive
An Exogenous Cause

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There has been much interest recently in the "battered child syndrome," but of the many causes of inadequate weight gain in infancy, the example presented here is one of the most unexpected and illustrates the danger of assuming too readily parental inadequacy or neglect.

Report of a Case

This girl was admitted to the Children's Hospital of Philadelphia at the age of 8 months in a state of emaciation and extreme weakness. Up until 6 months of age, she had fed well and development had been reportedly normal. From the age of 6 months, her appetite became poor and she lost weight. She had persistent coryzal symptoms with rattling in the chest, and a month later, she developed a cough which was more marked at night. Up until six weeks before admission, no undue concern was aroused by her symptoms and she was treated with various cough medicines and antibiotics by her physician. Subsequently, however, her appetite declined further and mild dysphagia developed, particularly on ingestion of solid foods. She had occasional mild respiratory difficulty and stridor. Over this interval, she lost 1 kg in weight.

On physical examination (Fig 1), she appeared pale, ill, and cachectic. She was moderately dehydrated and there was marked loss of subcutaneous tissue. There were several scratches and bruises on the face. A cavernous hemangioma was present on her upper lip. Her weight was 4.6 kg (10 lb 1 oz), well below the third percentile, and her length was 68 cm (27 in) (on the 50th percentile). Results of the examination of the ears, eyes, nose, and throat were within normal limits. Apart from slight intercostal retraction and inspiratory stridor when crying, no abnormalities were found in the chest. The results of the remainder of the physical examination were within normal limits.

X-ray examination of the neck revealed a large nut and bolt in the hypopharyngeal area compressing the lower part of the larynx and upper trachea anteriorly (Fig 2). There was diffuse perihilar and right upper lobe pneumonia.

Because of her poor clinical state, she was treated with antibiotics and intravenous fluids prior to removal of the foreign body. She developed progressive respiratory obstruction and stridor, and it became necessary to remove the nut and bolt as an emergency procedure.

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Fig 1.—Patient's appearance on admission.

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nut and bolt measured about 1 x 2 cm. It was lying in the left pyriform sinus, and the area showed moderate edema and some granulation tissue encroaching on the larynx. It was necessary to perform a tracheostomy four hours later due to increasing upper airway obstruction. Subsequently, the respiratory symptoms gradually improved. The tracheostomy tube was removed after six days. For the next three days there were recurrences of retractions and respiratory difficulty which finally disappeared. During the remaining two weeks in the hospital there were no further feeding difficulties and the patient gained 1 kg in weight (Fig 3).

Comment

When this child was first seen at the hospital there was considerable concern over the possibility that the clinical state had resulted from starvation and neglect. This impression was supported by knowledge of the parents’ poverty and a detailed feeding history which suggested inadequate dietary intake.

The relative lack of respiratory symptoms prior to hospitalization is surprising. Their dramatic progression appears to have coincided with dehydration. It is also possible that change in position of the foreign body may have resulted from repeated examination.