

MANAGEMENT OF STEAK HOUSE SYNDROME

To the Editor:

As a gastroenterologist, I was very disappointed in the article, "Management of Foreign Bodies in the Emergency Department" (Nagendran T: *Hospital Physician* 1999;35[9]:27-40), especially the section on food bolus at the gastroesophageal junction (steak house syndrome). Not only is it inappropriate to confirm a food impaction with barium, but this procedure can also be dangerous. I agree that cervical plain films are a good idea in this setting; however, barium can damage the trachea and bronchioles if aspirated, can lead to severe mediastinitis if perforation occurs, and can severely damage an endoscope.¹ The author's limited experience with food bolus ("one case of steak house syndrome was seen") leads credence to his idea that. . . "intravenous glucagon and/or gas-forming agents effectively relieve obstruction in most cases." This statement is far from the truth.² Most emergency department physicians and gastroenterologists can attest that, if a true food bolus exists, these modalities are a waste of time. The author does note that all patients with steak house syndrome "need further evaluation," a statement with which I completely agree.

The bottom line is that the diagnosis of food bolus at the gastroesophageal junction is made by history. A plain film of the neck is appropriate, and the emergency physician should call in the gastroenterologist early. Both the gastroenterologist and the patient will be grateful.

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In reply:

I thank Dr. DeBanto for his comments. First, Dr. DeBanto assumes that a consulting gastroenterologist is available in all hospitals, which is not true. Second, the article clearly addresses the complications of barium versus meglumine diatrizoate in the discussion of perforation and obstruction section on page 33. Confirming a food bolus obstruction by barium study is well accepted in the literature.^{3,4} All patients with food bolus obstruction do not have organic lesions; some of these patients have spasm, so a use for glucagon and gas-forming agents still exists.⁴⁻⁷ Third, endoscopies are expensive and are not without complications.

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REFERENCES

1. Castell DO, Richter JE, eds: *The Esophagus*, 3rd ed. Philadelphia: Lippincott-Raven, 1999:335-348.
2. Tibbling L, Bjorkhoel A, Jansson E, Stenkvist M: Effect of spasmolytic drugs on esophageal foreign bodies. *Dysphagia* 1995;10:126-127.
3. Stack LB, Munter DW: Foreign bodies in the gastrointestinal tract. *Emerg Med Clin North Am* 1996;14:493-521.
4. Mohammed SH, Hegedus V: Dislodgement of impacted oesophageal foreign bodies with carbonated beverages. *Clin Radiol* 1986;37:589-592.
5. Robbins MI, Shortsleeve MJ: Treatment of acute esophageal food impaction with glucagon, an effervescent agent, and water. *AJR Am J Roentgenol* 1994;162:325-328.
6. Kaszar-Seibert DJ, Korn WT, Bindman DJ, Shortsleeve MJ: Treatment of acute esophageal food impaction with a combination of glucagon, effervescent agent, and water. *AJR Am J Roentgenol* 1990;154:533-534.
7. Karanjia ND, Rees M: The use of Coca-Cola in the management of bolus obstruction in benign oesophageal stricture. *Ann R Coll Surg Engl* 1993;75:94-95.