nosis and management is essential to avoid diagnostic delay and definitive treatment (Ghaly et al, 2009). Khanna et al (2006) categorized the causes of localized facial swelling based on pattern of onset (*Table 1*).

The commonest dental cause of the acute onset swelling and inflammation is a peri-apical tooth infection. In contrast Lee et al (2010) in a series of 121 patients undergoing surgery for unilateral sinus disease only three (3.1%, *n*=97) had cheek swelling at presentation. Conventional rhinology teaching also reports that isolated swelling of the cheek is an unusual finding in rhinosinusitis (Jones et al, 2002). A further review of the literature revealed several rare causes of rapid onset cheek swelling, including bleeding as a result of vitamin K deficiency (Myoken et al, 2010), facial lymphoma (Graham et al, 2009), and dentigerous cyst (Goyal et al, 2010).

This case and discussion illustrates the need for non-otolaryngology specialists to consider primary dental causes in cases of rapid onset mid-facial swelling over the maxillary sinus. BJHM

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LEARNING POINTS

- Maxillary sinus pathology is rare as a cause of localized cheek swelling.
- An isolated mid-facial swelling not involving the eye should be considered dental until proven otherwise.
- An early referral to the maxillofacial team may avoid the need for unnecessary investigations.
- The management of facial swelling often requires a multidisciplinary approach.

An unusual foreign body in the upper cervical oesophagus

A 71-year-old man presented with dysphagia, odynophagia and foreign body sensation in the throat, 3 days after eating a meal that contained fish. X-ray (*Figure 1*) revealed a radio-opaque foreign body in the cervical oesophagus at the cricoid cartilage level with thickening of the prevertebral tissues.

The foreign body was located in a less common site: the upper cervical oesophagus (the lower third is most common). This site usually presents the greatest difficulties for flexible endoscopic treatment. The patient therefore underwent a rigid pharyngo-oesophagoscopy under general anaesthesia when a sickle-shaped foreign body (4 x 1.5 cm) was extracted in one piece, identified later as a piece of crab shell (*Figure 2*). Postoperatively, the patient was closely observed for 48 hours and discharged after 3 days.

Sharp foreign bodies in the oesophagus can be associated with serious complications, e.g. oesophageal perforation and mediastinitis (associated with high mortality). Therefore, rapid, accurate diagnosis followed by appropriate timely endoscopic or surgical intervention is indicated. BJHM

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Figure 1. Radio-opaque ingested foreign body.

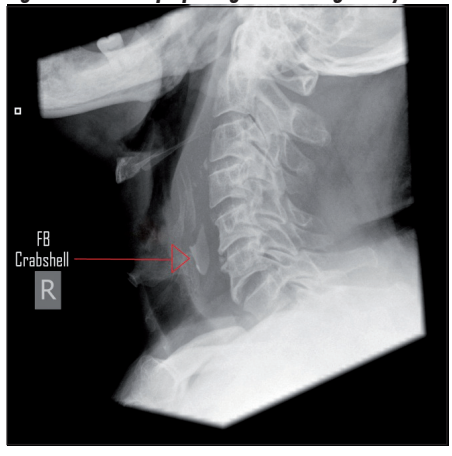

Figure 2. Sickle-shaped extracted foreign body (part of crab shell).