Button Battery Ingestion

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Current situation


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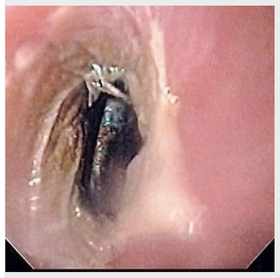
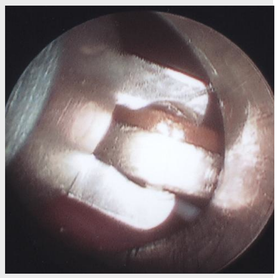
'Button battery' warning over child deaths in Manchester

14 October 2014 | Manchester

- Low level of awareness, including among medics
- Serious injury (caustic burn) within TWO HOURS
- Principles of treatment vary greatly across countries: trigger trauma calls in USA
- http://www.poison.org/battery/guideline.asp



a



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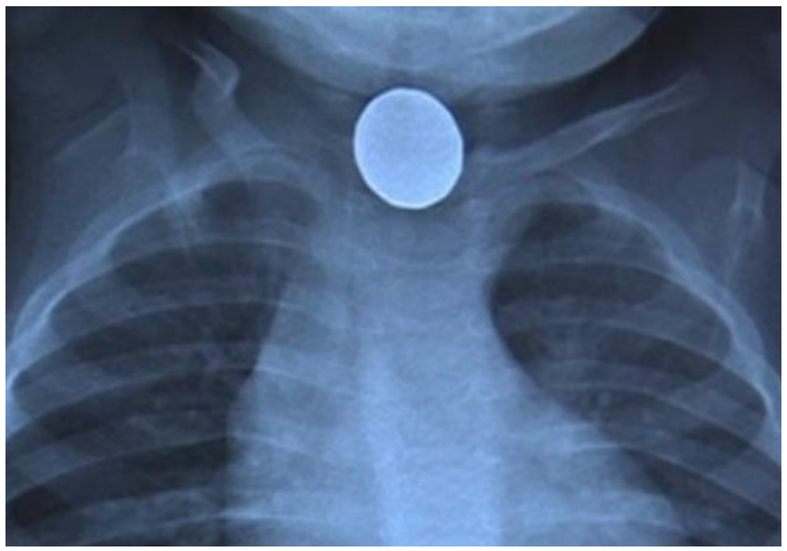

a. Endoscopic view of disk battery in oesophagus of a child demonstrating oesophageal burns.
b. Endoscopic view of a nickle and penny in the oesophagus of a child that was initially misdiagnosed as a disc battery.

Our proposals

- National multi-centre prospective audit
- Time to theatre
- Complications
- In collaboration with A&E (?PERUKI)

- Standard:
- All patients with battery in oesophagus should be taken to theatre for removal within TWO HOURS since ingestion

- Aims:
- To improve awareness amongst healthcare professional, thereby reducing diagnosis delay
- To improve awareness amongst parents through child safety campaign