The mule who took us for a ride
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ABSTRACT
Foreign body ingestion is not uncommon in patients with mental disorders, alcohol intoxication and for purposes of drug trafficking. Small objects pass spontaneously; however, larger ones may get stuck in the oesophagus, stomach or at narrow areas of the bowel. ‘Body packers’ is a term used to describe persons who swallow or insert drug-filled packets into a body cavity. They are also called ‘swallowers’, ‘internal carriers’, ‘couriers’ or ‘mules’. We report a 37-year-old previous drug abuser who presented with dysphagia. Upper GI endoscopy showed an oblong foreign body covered in plastic in the lower oesophagus. This could not be extracted and hence was pushed into the stomach. Three weeks later, he presented with bowel obstruction that was shown on abdominal radiograph and confirmed by CT indicating multiple dilated small bowel loops with a transition point in the terminal ileum where the ingested package was identified. The package was then removed through a longitudinal enterotomy. Ingested foreign bodies causing dysphagia should ideally be extracted endoscopically. If not possible, then a watch-and-wait policy may be justified. While most ingested objects pass spontaneously, unusual and larger ones may require surgical extraction. The contents, nature and reason for ingesting this strange object remain a mystery. With history of drug abuse and the consistent denial of knowingly swallowing that object, we can only conclude that the patient was trying to transport an illicit drug in the packet.

Foreign body ingestion is not uncommon in patients with mental disorders, alcohol intoxication and for purposes of drug trafficking. Small objects pass spontaneously; however, larger ones may get stuck in the oesophagus, stomach or at narrow areas of the bowel. ‘Body packers’ is a term used to describe persons who swallow or insert drug-filled packets into a body cavity in an attempt to smuggle them. They are also called ‘swallowers’, ‘internal carriers’, ‘couriers’ or ‘mules’. We report a 37-year-old previous drug abuser who presented with dysphagia. Upper GI endoscopy showed an oblong foreign body covered in plastic in the lower oesophagus. This could not be extracted and hence was pushed into the stomach. Three weeks later, he presented with bowel obstruction that was shown on abdominal radiograph and confirmed by CT indicating multiple dilated small bowel loops with a transition point in the terminal ileum where the ingested package was identified (Figure 2).

Laparotomy revealed the package in the terminal ileum with proximal dilated and distal collapsed bowel. It was removed via a longitudinal enterotomy (Figure 3). On opening the plastic cover, it turned out to be a wad of folded and tightly rolled up paper with illegible handwriting.

While the patient had a past history of substance abuse and had several gastroscopies for swallowing illicit substances, he claimed to have been reformed, and adamantly denied swallowing that object being surprised at its nature and contents.

Discussion
Endoscopic management of oesophageal foreign body include en bloc removal, piecemeal approach or advancement into the stomach. Conservative outpatient management is indicated in cases where the object has entered the stomach.

Case report
We present a 37-year-old male who presented with dysphagia. Upper GI endoscopy showed a foreign body in a plastic bag in the lower oesophagus, which could not be retrieved (Figure 1). Therefore, it was pushed into the stomach.

Three weeks later, he presented with symptoms and signs of bowel obstruction. Abdominal radiograph showed dilated loops of small bowel and a possible foreign body. Computerised tomography (CT) confirmed bowel obstruction with a transition point at the ileoceleal valve where the package was identified (Figure 2).

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Most ingested objects pass spontaneously within four days to four weeks. Surgical intervention should be considered if the object passes the stomach and remains in the same location for more than a week.5

We could not retrieve the package during the upper GI endoscopy. Given that it was plastic and soft (measuring around 5x3cm), it was pushed into the stomach, hoping it would pass spontaneously. There is still controversy regarding the push technique because it carries a risk of perforation when performed without examining the distal oesophagus first.6 Some studies have reported that this technique has a success rate of over 90% and is the primary method for managing food bolus ingestion with minimal complications.7,8

Plain abdominal radiography has been reported to be diagnostic for swallowed packets (with sensitivity of 90%) as it may show ‘rosette-like’ or ‘double-condom’ signs; however, contrast CT is more sensitive.9 In our case, plain radiography showed signs of obstruction, with a suspicious foreign body.
In body packers, surgical intervention is required in less than 1% of cases. Perforation is an absolute indication, whereas unsuccessful endoscopic retrieval is a relative one. In our case, the patient underwent laparotomy and the package retrieved as soon as obstruction was confirmed radiologically.

**Conclusion**

Ingested foreign bodies causing dysphagia should ideally be extracted endoscopically. If not possible, then a watch-and-wait policy may be justified. While most ingested objects pass spontaneously, unusual and larger ones may require surgical extraction.

The contents, nature and reason for ingesting this strange object remain a mystery. With history of drug abuse and the consistent denial of knowingly swallowing that object, we can only conclude that the patient was trying to transport an illicit drug in the packet.

**Competing interests:** Nil.

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