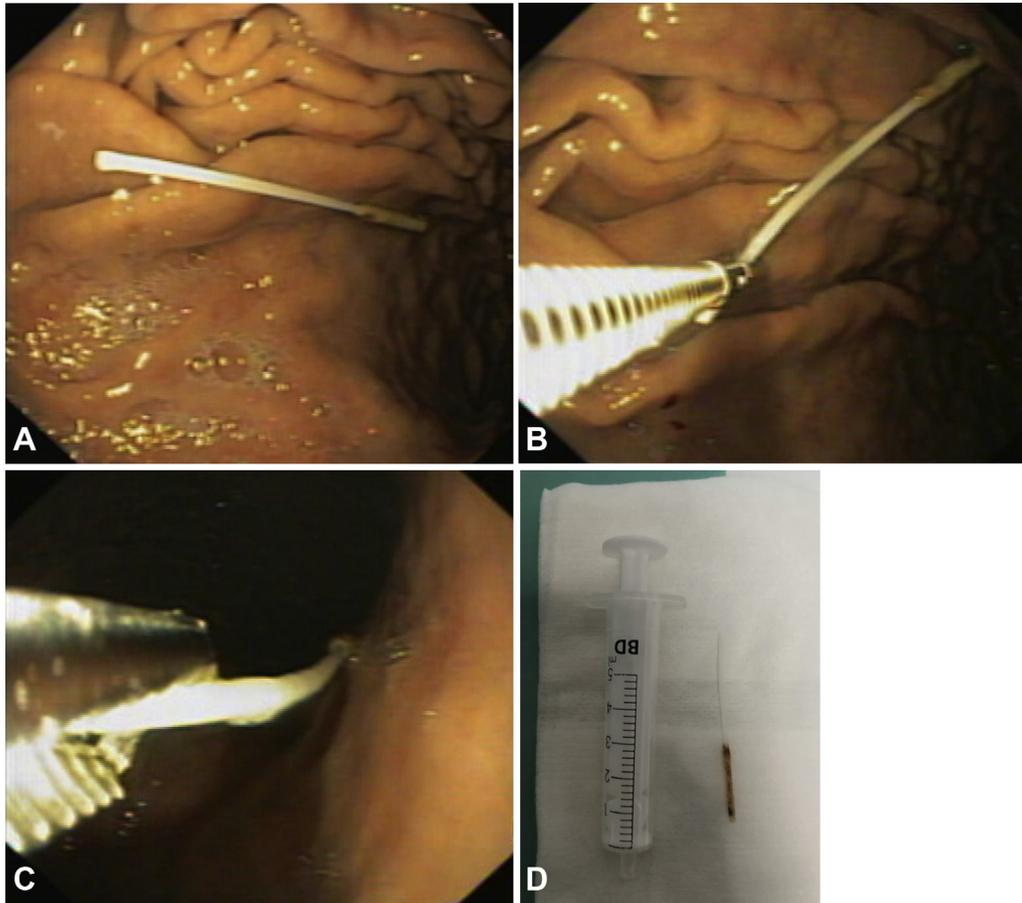




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An unusual collateral damage of COVID-19 pandemic



A 64-year-old man was admitted to the gastroenterology department after a nasopharyngeal swab broke inside his left nasal fossa during testing for SARS-CoV-2. The patient had no symptoms, and the physical examination was unremarkable.

The patient was examined by an otorhinolaryngologic physician. Nasofibroscopy was performed but did not detect the foreign body. Therefore, and considering that the swab had a sharp-pointed part (the broken swab's extremity), EGD was performed. To perform EGD as soon as possible, the patient was considered to be SARS-CoV-2 positive, and adequate personal protective equipment was

used: waterproof gown, 2 pairs of gloves, hairnet, goggles, shoe covers, and N95 respirator.

In the gastric cavity, the broken swab was visualized and seen to be approximately 6 cm long (A). The foreign body was retrieved with grasping forceps by the broken swab's extremity, the cotton part being left free (B, C, D). The reassessment EGD did not show any lesions. The patient remained asymptomatic and was discharged.

To our knowledge, this is the first reported case of a broken nasopharyngeal swab retrieved from the gastric cavity by EGD. During the procedure, it is important to

consider the use of grasping forceps in the broken extremity (sharp part) because the cotton part is blunt and smooth.

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DISCLOSURE

All authors disclosed no financial relationships.

<https://doi.org/10.1016/j.gie.2020.06.017>

Commentary

This case illustrates the law of unintended consequences. This unfortunate individual underwent COVID-19 testing, and unfortunately the swab broke off and found its way to the stomach, where it required endoscopic retrieval. As foreign bodies in the GI tract go, this is a simple one to identify and remove.

This case raises several questions. First, what was the original indication for COVID-19 testing? Second, most units require a negative COVID test result before performing EGD. Did this patient require a second COVID-19 test before undergoing the EGD to retrieve the swab from the first COVID test? If so, I imagine there was a delicate conversation with the patient before he was retested. Third, what was the fate of the broken swab after removal? Was it sent to the laboratory for analysis for COVID status? Inquiring minds want to know. As many readers of this article have experienced firsthand, a COVID swab goes deeply into the nasopharynx, so you can easily see how a broken swab could end up in the stomach.

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Emulsified stromal vascular fraction tissue grafting: a new frontier in the treatment of esophageal fistulas



A 54-year-old woman was admitted in an acute life-threatening condition with right pleural empyema in Boerhaave syndrome during chemotherapy. After right pleural surgical toilette, a Micro-Tech fistula occluding stent (A 30, B24-mm, Micro-Tech, Nanjing, China) was placed and fixed with Apollo overstitch during gastroscopy to occlude the perforation of the distal part of the esophagus. After resolution of the sepsis, the patient was discharged with normal oral intake. Two months later, stent removal was attempted, but the patient's clinical condition dramatically worsened, and a gastrografin esophagogram showed persistence of a 2-cm esophagopleural fistula (A). Therefore, a multidisciplinary panel (thoracic and plastic surgeons, and endoscopists) decided to exploit the anti-inflammatory and regenerative tissue capacities of emulsified stromal vascular fraction tissue (tSVFem) grafting (already widely used in other medical fields) for curing (the first attempt in a human being) the fistula, which was refractory to any conservative treatment. Twenty milliliters of autologous "microfat," harvested

from the subcutaneous tissue with specially designed microcannula, were emulsified by sequential filters. After centrifugation and removal of oil and liquid fractions, the living regenerative tissue (tSVFem) was obtained. During esophagoscopy, 10 ml "microfat" was injected into the fistula through a 6F catheter and the tSVFem into the submucosa of the fistula borders (B) by a 22-gauge needle. Ten days later, complete resolution of the fistula was documented (C, D). The patient's condition improved, she restarted oral intake, and she was discharged, with an uneventful follow-up visit 3 months later.

DISCLOSURE

I. Bošković: Consultant for Apollo Endosurgery, Cook Medical, and Boston Scientific; board member for Endo Tools; research grant recipient from Apollo Endosurgery; food and beverage compensation from Apollo Endosurgery, Cook Medical, Boston Scientific, and Endo Tools.