necessary was supplemented by a letter to the general practitioner and a telephone call or home visit to the patient.

Thirty two patients presented with cephalgia fugax and three with migraine. The mean age of the patients was 28 (range 14–56), and 24 were women. The headaches were bilateral in 22 cases and occurred in the temporoparietal area in 30 and anywhere in the head in eight. The most consistent feature of the pain was its character, which was sharp, stabbing, darting, or shooting in all cases. Another characteristic was the brief duration of the pain: 24 patients said that it lasted from a split second to a few seconds, and 30 that it lasted for less than a minute; it never lasted for longer than five minutes. The frequency of the headaches ranged from five times a day to once a week, and 28 patients had had them for longer than four or five years. Migraine and tension headaches occurred in nine and five cases respectively. Trigger events were uncommon (three patients). None of the patients had neurological signs, and there were no gastrointestinal symptoms, although a few patients reported vague lightness in the head and shimmering in the eyes during the attack. Eleven patients had a relative or close friend who had had a cerebral tumour, stroke, epilepsy, or meningitis, and this may have contributed to their seeking advice.

Investigations were conducted in only six patients; two computed tomograms, two isotope scans, an electroencephalogram, and a skull x ray film were normal.

Follow up (mean duration 4.5 years, range 0.5–13.0 years) was successful in 37 patients and none developed a disorder related to headache. Twenty six patients still had the symptoms intermittently; in 10 they remitted within a year.

Comment

No explanation is offered for this symptom. Pearce referred to it in a paper devoted mainly to unnamed symptoms, including the "needle in the eye syndrome," of which we have no experience but which we would regard as part of the range of cephalgia fugax.² He also described the "exploding head" and a brief chest pain that we call "pectoralgia fugax." Drummond and Lance found that pain like a blow from an ice pick occurred in 39% and "ice cream headache" in 37% of a series of patients with migraine.³ The mechanism of ice cream headache, which develops quickly after ingestion of a cold substance, is not known. Drummond and Lance speculated that in patients with migraine pain pathways may be hyperexcitable, leading to more frequent occurrence of brief head pains and ice cream headache.³

We suggest that the term cephalgia fugax is better than ice pick headache and think that this symptom should be generally recognised so that patients can be reassured without undergoing needless investigation. A patient who has cephalgia fugax might have an unrelated cerebral tumour, but other headaches and manifestations of focal neurological disease would probably indicate this.

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2 Pearce JMS. What's in a name. *World Medicine* 1979;14:77-8.

3 Drummond PD, Lance JW. Neurovascular disturbances in headache patients. *Clin Exp Neurol* 1984;20:93-9.

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Missing denture as a cause of recurrent laryngeal nerve palsy

We report an unusual case of recurrent laryngeal nerve palsy caused by prolonged retention of an oesophageal foreign body.

Case report

A 46 year old man presented with a history of hoarseness and mild dysphagia. Eighteen months previously he had been admitted to hospital with minor concussion and bruising to the head and neck after an assault while intoxicated. He had complained of moderate dysphagia for five days, ascribed to bruising of the larynx; neck x ray pictures looked normal. Hoarseness had developed some two months later and after some early improvement had remained constant. The dysphagia had returned over the past six months.

Examination found his voice weak and dysphonic. He had tenderness in the neck at the cricoid level, especially on eliciting crepitus, and a left vocal cord

palsy. A barium swallow examination showed pronounced widening of the postcricoid soft tissue shadow, reported as a probable neoplasm (figure). At rigid endoscopy a jagged piece of denture plate 3×3 cm was found impacted in a mass

Lateral contrast film of pharynx showing widening of postcricoid soft tissue shadow. (In retrospect plate may be seen lying against anterior wall of cervical oesophagus (arrowed).)

of scarred mucosa in the cervical oesophagus and removed. Postoperatively his dysphagia settled quickly, though the palsy and hoarseness remained. The patient later remembered that he had lost part of his denture at the time of the assault.

Comment

Loss of movement of one vocal fold is seen relatively often by otolaryngologists. The most common causes are malignant disease (25%), surgical trauma (20%), idiopathic (13%), inflammatory (13%), non-surgical trauma (11%), and neurological (7%).¹ No recorded case due to a retained foreign body could be found. The immobility in our patient was not due to cicatricial fixation of the hemilarynx after an unrecognised laryngeal fracture as it was passively mobile at endoscopy. The delayed onset of hoarseness suggests that it was due to impairment of the recurrent laryngeal nerve in perioesophageal fibrosis.

Prolonged retention of a foreign body in the oesophagus is extremely unusual, though there is one recorded case of a wooden button retained for 17 years.² Broken or partial dentures may occasionally be swallowed, often while the patient is asleep or drunk.³

Unfortunately, radiology cannot be relied on to detect the presence of denture material as this is often radiolucent.⁴ Endoscopy is indicated for persistent symptoms even with negative radiological findings, as once impacted the chance of spontaneous passage is small.⁵

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