A 4-YR-OLD, 13-kg girl presented to the emergency department in cardiopulmonary arrest after acute episodes of bright red hematemesis. The patient had no witnessed foreign body ingestion or past medical history. Once stabilized, the patient was transferred to the pediatric intensive care unit. Chest radiograph (fig. A) revealed a 23-mm, round foreign body with a peripheral rim (suggesting the presence of a battery) in the central mediastinum within the distal esophagus posterior to the heart. She was taken to the operating room for emergency thoracotomy. Upon transfer to the operating room table, the patient experienced cardiopulmonary arrest. The surgeons cross clamped the aorta and initiated open-chest cardiopulmonary resuscitation. Despite ongoing resuscitation, the patient never regained a sustainable cardiac rhythm and expired. Postmortem examination confirmed the presence of a battery-induced aortoesophageal fistula (fig. B).

Battery ingestion is an increasing hazard with potentially fatal clinical implications. Public awareness is essential in preventing complications because early recognition of battery ingestion and removal is key to therapeutic management. If battery ingestion is suspected, a chest radiograph should be obtained immediately. Patients with ingested batteries larger than 12 mm should go to the operating room within 2 h for endoscopic removal and inspection of the esophageal mucosa. Even if the battery is smaller than 12 mm, patients are still at risk for injury or death. It is essential to make a decision based on symptoms and clinical judgment. Failure to remove batteries within 2 h can lead to esophageal necrosis and aortoesophageal fistulas. After removal of the battery, patients with mucosal injuries should be observed for delayed complications such as abscesses, perforations, mediastinitis, and strictures for up to several months.