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Sacroccocygeal Dimples

Many newborns are referred to pediatric surgeons because a small pit, hole or sinus is identified over the skin of the sacroccocygeal region. Those located in the coccygeal area (below the intergluteal crease) are usually shallow blind ending dimples with no significance and disappear with growth of the child. Some are deep enough (1 cm) and feces may be caught in them giving the false impression that a fistulous tract is present. On few occasions the contamination may lead to a local infectious process with suppuration. If this situation arises, excision of the dimple is curative. This dimples should not be confused with the more serious situation of a sacral sinus tract (dimple above the intergluteal fold) sometimes associated with an underlying spina bifida occulta. This tract may communicate with the spinal cord and be a source of recurrent episodes of meningitis. An MRI study of the sacral area may help delineate the tract from the skin to the spinal cord structures. Excision at the time of diagnosis should be done by a physician with sound knowledge of neuroanatomy. Dermal sinuses and inclusion tumors may lead to spinal cord tethering and progressive neurologic deterioration.

Sigmoid Volvulus

Sigmoid volvulus is a rare cause of mechanical intestinal obstruction in the pediatric age group. Of all colonic volvulus (cecum, transverse, and sigmoid) this is the most common (~80%). Many reports come from African children. Predisposing conditions are: irregular bowel behavior, consumption of high fiber diet, Hirschsprung's disease, chronic constipation, abnormally long sigmoid flexure, a/o absence of mesosigmoid. The condition arises after clockwise rotation of a redundant sigmoid with a fixed point. Clinically the child presents with abdominal pain of sudden onset over the left lower quadrant, vomiting and obstipation. There may be tenderness, distension, and a palpable mass. Plain abdominal films (classic omega sign) may not yield a diagnosis. Contrast study of the colon (cysto-conray enema) may be diagnostic and therapeutic. Sigmoidoscopy (with tube decompression) can achieve derotation of the bowel. Emergency surgery is needed when there's evidence of strangulation or inability to derotate the volvulus. Sigmoid

resection is definitive treatment for children, but nonoperative decompression to allow for elective resection should be attempted in patients with no evidence of peritonitis. The mortality in the acute setting is significant in poor risk patients, the very young, and patients with associated anomalies.

Omphalopagus

Omphalopagus are twins joined through their abdomen and usually sharing liver (hepatic bridge), biliary tree, gastrointestinal, and genitourinary tracts. Conjoined twins occur in one of every 50,000 births. Females predominate and most (two-third) will not survive. Commonly type of conjoined twins reported are in order of frequency: thoraco-omphalopagus, thoracopagus, omphalopagus, parasitic twins and craniopagus. A high incidence of births defects not linked to conjoining (cardiac, neural tube, and orofascial cleft defects) explains the high rate of late mortality in those that survive early separation. Early prenatal diagnosis and assessment of the degree of conjoining provide the couple the option of pregnancy termination, or the physician use of cesarean section to improve survival. Separation is best delayed until the twins are relatively mature and developed (more than six months of age). Emergency separation has been needed with one twin stillborn, with gastroschisis or after development of enterocolitis. Although multiple imaging studies will be required to determine the extent of anatomical union, MRI gives information on hepato-biliary and cardiovascular structures that enable planning a safe separation. Doppler echo can also adequately document the heart status noninvasively avoiding the need for cardiac catheterization

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