



PEDIATRIC SURGERY Update ©

Vol 10 No 06 JUNE 1998

'Official Publication of the Puerto Rico Association of Pediatric Surgeons'

Imperforate Hymen

During infancy an imperforate hymen (IH) might produce a mucocolpos, and if not corrected by puberty a hematocolpos or hydrometrocolpos. As the vagina and uterus fills the hymen membrane distends and bulges, protruding as a globular mass beyond the introitus (yellowish or grayish white). IH results when mesoderm of the primitive streak abnormally invades the urogenital portion of the cloacal membrane. Clinically the infant presents with an abdomino-pelvic mass, constipation, symptoms of urinary retention and dilatation of the upper urinary tract. Other times amenorrhea during early adolescence might be uncovered an IH. Differential diagnosis includes: labial adhesions, vaginal agenesis, vaginal cyst, ectopic ureter, prolapse urethra and ureterocele. US and MRI are useful diagnostic studies. Diagnosis can be made prenatally as early as the second trimester of pregnancy. IH must be corrected by surgery when discover. At the time of surgery the urethra is inspected and catheterized, the IH incised and the vagina evacuated. Cut edges are sutured to the vagina mucosa.

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Esophageal Perforation

Most esophageal perforation in newborns occurs in the cervical portion while trying to intubate the trachea (iatrogenic). Injury produced by laryngoscope blades, pharyngeal suction catheters, nasogastric and endotracheal tubes are generally unrecognized until the baby develops signs of esophageal obstruction mimicking esophageal atresia (excessive salivation, cyanotic spells, and regurgitation upon feeding), radiographic evidence of pharyngeal perforation (usually in the posterior mediastinum) or a right-sided pneumothorax. The child most at risk is the small for gestational age or premature baby. Types of injuries identified: 1) pharyngeal pseudodiverticulum, 2) mucosal perforation posteriorly and parallel to the esophagus, and 3) intrapleural perforation. Diagnosis can be strongly suspected from the findings on the chest x ray or confirmed by performing an esophagogram ('double esophagus' sign). Management depends on extent and location of injury. Overall, perforations of the pharynx and esophagus in neonates can be

satisfactorily managed medically with antibiotics and parenteral nutrition except in cases that require mediastinal decompression or chest tube placement. Fluoroscopically placed NG tubes will allow gastric feedings. Key to prevention: use of soft-tipped suction catheters and nasogastric tubes and careful visualization of the cords during endotracheal intubation. Metal stylets to direct endotracheal tubes are dangerous. Perforations in older infants and children are associated to foreign body, esophageal dilatation, trauma or lye ingestion dealt depending on their causative factor.

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Dysgerminoma

Thought to arise from the germ cells of the sexually indifferent stages of gonadogenesis, this malignant ovarian tumor is equivalent to the seminoma of testes in males. Occur most often in adolescents (60% of dysgerminoma develops during the first two decades of life), as a rapidly growing asymptomatic heavy solid pelvic mass. Grossly characterized as a smooth surface, nodular, encapsulated solid tumor. Rarely, they may secrete hormones (gonadotropin, PTH-like substance) producing sexual precocity or hypercalcemia. Unilateral salpingo-oophorectomy is adequate surgery if the tumor is unilateral, encapsulated, mobile, the opposite ovary is normal, there is no ascites and the retroperitoneal nodes are not enlarged or abnormal. Ascites, bilateral tumors and evidence of extension are bad prognosis signs and should be managed by total abdominal hysterectomy and bilateral salpingo-oophorectomy with irradiation. Recurrence of the tumor during the first two years after treatment is an ominous sign. Teratomatous or trophoblastic foci heralds a bad prognosis.

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