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Fibrosing Pancreatitis

Chronic pancreatitis does occur in young children and is most commonly caused by hereditary pancreatitis or idiopathic fibrosing pancreatitis. Fibrosing pancreatitis is a chronic process of unknown etiology characterized by extensive infiltration of the pancreatic parenchyma by fibrous tissue. Most reported cases are females. Fibrosing pancreatitis is a rare cause of intermittent colicky abdominal pain, recurrent vomiting, weight loss, steatorrhea, pancreatic exocrine and endocrine insufficiency and obstructive jaundice that can be seen in early childhood. In cases of obstructive jaundice the sonographic demonstration of a dilated biliary tree and common bile duct compressed by an enlarged pancreas may be the first suggestion of this disease process. Diagnosis is suggested by imaging studies (US, CT-Scan, MRCP or ERCP) revealing diffuse enlargement of the pancreas, predominantly the head. Open pancreatic biopsy showing acinar cell atrophy and extensive fibrosis is diagnostic. Cystic fibrosis should be excluded by appropriate testing. Management should be directed toward complications. Children with obstructive jaundice should undergo sphincterotomy to drain the common bile duct obstruction or bilio-enteric bypass.

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Foreign Body Ingestion

Accidental foreign body (FB) ingestion such as - coins, fish bones, toys plastic parts, jewels, batteries, safety pin, needles, etc. - is a common problem in children, specially infants and toddlers. Infants usually swallow button batteries while coins are the most frequently swallowed objects in children over the age of three years. No child ingests more than one FB. Management of esophageal FB differs from the rest of the gastrointestinal tract. Diagnosis is made by either chest-x-ray, barium swallow or esophagoscopy. They

should be suspected when the child develops excessive salivation, vomiting, respiratory distress, recent-onset asthma, dysphagia and hematemesis. FB in the esophagus should be removed urgently to avoid erosion and perforation, specially those lodge in the upper-third of the esophagus. They can be removed using flexible fiberoptic endoscopy, balloon catheter or bougienage. Beyond the stomach, foreign body should be managed conservatively. This means follow-up visits until the FB spontaneously appears in the feces. In cases of coins ingestion serious complications are extremely rare. There is no need to x-ray monitor coins or any other metallic FB. More than 85% of all ingested FB passes spontaneously through the rectum despite nature or length. Surgery will be needed in less than 2% of all ingested FB. Patients with previous abdominal surgery are at increased risk. Development of abdominal pain, distension or profuse bleeding is an indication to remove the FB surgically.

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Inflammatory Pseudotumor

Inflammatory pseudotumor, better known as inflammatory myofibroblastic tumor (IMT) is a rare benign solid tumor mimicking a malignant neoplasm that grows to a large size. Though most commonly encountered in the lung and mediastinum, IMT has also been identified in the abdomen (liver, pancreas, stomach, omentum), retroperitoneum, pelvis (bladder), and extremity of children. Imaging studies suggest a well-circumscribed mass of soft tissue density producing displacement or invasion of surrounding structures. Needle biopsy is not considered a reliable diagnostic method. Diagnosis must be established by histology after surgical excision. Pathologically there is proliferation of plasma cells, lymphocytes and histiocytes in a benign looking spindle-shaped stroma (myofibroblasts). Etiology is unknown. Symptoms at presentation depend on site of development. Total excision of the lesion is sufficient for accurate treatment in most cases. Recurrence is common and should also be managed with surgery. Adjuvant therapy has limited application.

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* Edited by: **Humberto L. Lugo-Vicente, MD, FACS, FAAP**

Professor/Associate Director of Pediatric Surgery, University of Puerto Rico School of Medicine and
University Pediatric Hospital, Rio Piedras, Puerto Rico.

Address: P.O. Box 10426, Caparra Heights Station, San Juan, Puerto Rico USA 00922-0426.

Tel (787)-786-3495 Fax (787)-720-6103 E-mail: *titolugo@coqui.net*

Internet: <http://home.coqui.net/titolugo>

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