



Human Tail

The human tails refers to a extremely rare and benign condition where a child is born with a persistent vestigial tail-like cutaneous structure in the lumbosacroccocygeal region. Pathologically, two types of human tails have been recognized: the true and pseudo human tail. The true human tail arises from the most distal remnant of the embryonic tail lacking bone, cartilage, notochord and spinal cord. Contains a central core of mature fatty tissue divided into small lobules by thin fibrous septa with small blood vessels and nerve fibers scattered. The true tail arises by retention of structures found normally in fetal development. It may be as long as 13 cm, can move and contract, and occurs twice as often in males as in females. The pseudotail is a short, stump-like structure. Spina bifida (dysraphism) is the most frequent coexisting anomaly in both anatomical variants (50%). Other associated lesions include tethered cord syndrome, lipomas, teratomas and gliomas. Investigation of children born with human tail appendages should include a thorough neurological examination, plain x-ray films of the lumbo-sacral region and contrast MRI imaging looking for dysraphism and associated lesions. Management consist of surgical excision of the vestigial tail and repair of the dysraphism. Long-term follow-up for possible sequelae after surgery, especially in cases with spinal dysraphism, is necessary.

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Vaginal Prolapse

Vaginal prolapse in the newborn period is a condition reported rarely. It usually occurs during the first few days of life and presents as a tumor mass protruding from the vulva. The genital prolapse can include both the vagina and uterus. Genital prolapse in this age group is associated with a congenital pelvic neuropathy (myelomeningocele and spina bifida oclta), lesions affecting the development of the levator muscles, primary support of the pelvic organs. Though most cases are seen in babies with central nervous system defects, the condition can also be seen in normal newborn babies born with intrauterine

growth retardation. Initial management consists of digital manual reduction. Unfortunately, most cases are often resistant to simple reduction. If the prolapse recurs the wearing of a tiny pessary made from a rolled and tied one-inch penrose drain is introduced into the vagina. The pessary can be removed for cleansing and continued to be used for several weeks until the lax tissues adhere laterally. Should the prolapse be severe and repetitive, temporary sewing together the posterior half of the labia minora and majora together can be done. The suture is removed after they have been in place for two weeks. On a few occasions ventral suspension of the uterus has been deemed necessary.

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Fibroadenoma

Fibroadenoma is a common benign tumor found in the breast of adolescent girls. It is also considered the most common discrete solid mass found within the adolescent breast tissue. Most girls harboring a fibroadenoma have between thirteen and 16 years of age, the tumor is slow growing, tends to develop in the upper outer quadrant and is more common in African-American race. Though females may develop breast masses early in life, the risk of malignancy is extremely low. The tumor is usually solitary, with an average diameter of two to 4 cm, characterized by rich cellular stroma and prominent glandular epithelium. At physical exam the mass feels like a well-circumscribed movable nodule. Fibroadenomas may be related to an exaggerated local response to the estrogenic effects of puberty. Mammography, due to the inherent radiation risk and dense fibrous tissue, is not recommended for routine screening or routine imaging of breast masses in adolescents. Alternatively, sonography of the breast is diagnostic on most cases. The tumor looks well-circumscribe, hyperechoic and homogenous on ultrasound. Ten percent of cases harbor a giant juvenile fibroadenoma, a large lesion that distorts the normal breast architecture eroding through the skin and areolar complex. Management of fibroadenoma could be observation or cryoablation. Growing, symptomatic or anxiety-producing masses should be managed with excision through a periareolar incision to preserve cosmesis.

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