

PEDIATRIC SURGERY Update 8 Vol. 25 No. 01 JULY 2005

Osteochondroma

Osteochondroma is the most common benign bone exostosis found in children. Osteochondroma most frequently arise sporadically and as a solitary lesion, but may also arise associated with hereditary multiple exostosis. Hereditary multiple exostosis is an autosomal dominant disorder in which the clinical hallmark is the growth of bony protuberances from long bones causing a variety of orthopedic deformities. In hereditary multiple osteochondromas the prevalence is one in 50,000 individuals. Ten percent of affected children have no family history of multiple exostosis. Median age at the time of diagnosis is three years. Most cases present with an obvious deformity of the forearm, followed by an inequality in the lengths of the limbs, an angular deformity of the knee, or a deformity of the ankle. Symptomatics complications of osteochondroma consists of pain, fracture, osseous deformity limiting range of motion, vascular injury, neurological compromise, bursa formation and malignant transformation (chondrosarcoma). MRI is the ideal imaging modality in the diagnostic evaluation of symptomatic complications of osteochondromas and often avoids the need for further imaging. Spontaneous resolution of a solitary osteochondroma is rare. Management of symptomatic osteochondromas is surgical excision. Surgical complications associated with excision consist of peroneal neurapraxias, arterial laceration, compartment syndrome and fibular fracture. The surgical risk for the management of osteochondromas is low.

References:

1- Schmale GA, Conrad EU 3rd, Raskind WH: The natural history of hereditary multiple exostoses. J Bone Joint Surg Am 76(7):986-92, 1994

2- Wicklund CL, Pauli RM, Johnston D, Hecht JT: Natural history study of hereditary multiple exostoses. Am J Med Genet 55(1):43-6, 1995

3- Wirganowicz PZ, Watts HG: Surgical risk for elective excision of benign exostoses. J Pediatr Orthop 17(4):455-9, 1997

4- Mehta M, White LM, Knapp T, Kandel RA, Wunder JS, Bell RS. MR imaging of symptomatic osteochondromas with pathological correlation. Skeletal Radiol 27(8):427-33, 1998

5- Ahmed AR, Tan TS, Unni KK, Collins MS, Wenger DE, Sim FH: Secondary chondrosarcoma in osteochondroma: report of 107 patients. Clin Orthop Relat Res (411):193-206, 2003

6- Claikens B, Brys P, Samson I, Baert AL: Spontaneous resolution of a solitary osteochondroma. Skeletal Radiol 27(1):53-5, 1998

Suture Granuloma

Suture granuloma, commonly known as a stitch abscess, is a fairly common benign complication seen after surgery. Suture material is a foreign body that causes local irritation and tissue necrosis. Suture granuloma can occur many years after the primary surgical procedure. The most common suture causing suture granuloma is braided silk material, a non-absorbable suture. Monofilament and absorbable sutures carry a lower risk of infection. At skin or subcutaneous level, the granuloma presents as a chronic intermittent indolent infection with a burrow sinus, with no fever or signs of systemic infection. Diagnosis is suggested with ultrasound (hypoechoic lesion). Removal of the suture material is curative. The intra-abdominal presence of foreign material is an important cause of adhesion formation. Therefore, intra-abdominal contamination with foreign material should be minimized. Suture granulomas mimic neoplasms in clinical appearance. Suture granuloma can occur in the bronchial stump after lung resection, in the lung parenchyma after segmentectomy or as a paravesical mass or abscess after inguinal hernia repair. The paravesical abscess granuloma causes urinary discomfort, swelling, tenderness and microscopic hematuria. Again, definitive treatment is removal of the infected suture material (silk).

References:

1- Brunsvold MA, Reding ME, Kornman KS: Infected suture granuloma: a case report. Int J Oral Maxillofac Implants 6(2):215-7, 1991

2- Lynch TH, Waymont B, Beacock CJ, Wallace DM: Paravesical suture granuloma: a problem following herniorrhaphy. J Urol 147(2):460-2, 1992

3- Nagar H: Stitch granulomas following inguinal herniotomy: a 10-year review. J Pediatr Surg. 28(11):1505-7, 1993

4- Luijendijk RW, de Lange DC, Wauters CC, Hop WC, Duron JJ, Pailler JL, Camprodon BR, Holmdahl L, van Geldorp HJ, Jeekel J: Foreign material in postoperative adhesions. Ann Surg. 223(3):242-8, 1996

5- Nagar H, Kessler A, Graif M: The role of ultrasound in the diagnosis of stitch granulomas following paediatric herniotomy. Pediatr Radiol. 29(11):803-6, 1999

6- Imamoglu M, Cay A, Sarihan H, Ahmetoglu A, Ozdemir O: Paravesical abscess as an unusual late complication of inguinal hernia repair in children. J Urol. 171(3):1268-70, 2004

Vacuum-Assisted Closure

Vacuum-assisted closure (VAC) is a novel method utilized to promote expedite open wound closure. The technique consists of placing an open cell foam into the wound, sealing the site with an adhesive drape while applying subatmospheric pressure (125 mmHg below ambient) transmitted to the wound in a controlled manner. The technique removes chronic edema and decreases bacterial colonization leading to increased localized blood flow. VAC utilized in acute and chronic open wounds hasten granulation tissue formation. VAC has shown to be cost effective in the management of complex pilonidal sinus disease, sacral and extremity ulcers, sternal and spinal contaminated wounds, traumatic soft tissue wounds, diabetic foot ulcers, vascular insufficiency ulcers and extensive compartmental tissue loss areas. VAC therapy reduces the number of days to healing, reduces hospital stay, affords fewer dressing changes, allows mobility without bulky bandages and faster return to school or work. Further advantages consist of a clean closed system measuring fluid loss, change on a periodic basis rather than daily and enhancement of wound contraction. Complications with VAC therapy are uncommon.

References:

1- Morykwas MJ, Argenta LC, Shelton-Brown EI, McGuirt W: Vacuum-assisted closure: a new method for

wound control and treatment: animal studies and basic foundation. Ann Plast Surg. 38(6):553-62, 1997 2- McGuinness JG, Winter DC, O'Connell PR: Vacuum-assisted closure of a complex pilonidal sinus. Dis Colon Rectum. 46(2):274-6, 2003

3- Sibbald RG, Mahoney J; V.A.C. Therapy Canadian Consensus Group: A consensus report on the use of vacuum-assisted closure in chronic, difficult-to-heal wounds. Ostomy Wound Manage. 49(11):52-66, 2003 4- Antony S, Terrazas S: A retrospective study: clinical experience using vacuum-assisted closure in the treatment of wounds. J Natl Med Assoc. 96(8):1073-7, 2004

5- Caniano DA, Ruth B, Teich S: Wound management with vacuum-assisted closure: experience in 51 pediatric patients. J Pediatr Surg. 40(1):128-32, 2005

6- Clubley L, Harper L: Using negative pressure therapy for healing of a sternal wound. Nurs Times. 101(16):44-6, 2005

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

Professor /Academic Director of Pediatric Surgery, University of Puerto Rico - School of Medicine, 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.cogui.net/titolugo

8 PSU 1993-2005 ISSN 1089-7739