



PEDIATRIC SURGERY Update © **Vol. 27 No. 01 JULY 2006**

Utricle Cysts

Incomplete regression of the müllerian duct system in the male prostatic urethra produces a cystic structure of variable size that will persist in the midline between the bladder and the rectum known as utricle cyst. Possibility of persistence of müllerian remnants cyst is increased in children born with penoscrotal or perineal hypospadias, undescended testis and unilateral renal agenesis. The presence of an utricle cyst can cause lower urinary tract irritative or obstructive symptoms, epididimitis, hematuria, urinary incontinence, oligospermia, constipation, pyuria or an abdominal mass. Rectal exam can palpate the cystic mass. The diagnosis is established with cystourethroscopy or voiding cystourethrogram. Most utricle cysts can be managed medically. The few that enlarge and produce significant symptoms should be surgically resected. The surgical approach to the posterior prostatic area of a child urethra can be very difficult due to the proximity of these lesions to the ejaculatory ducts, pelvic nerves, rectum, vas deferens and ureters. Transurethral resection of the cyst roof does not produce good long term results. The suprapubic transvesical approach has been most widely use in cysts that are large enough to occupy part of the abdominal cavity. The posterior sagittal approach with lateral mobilization of the rectum is suited for medium size (grade III) utricle cysts resection. There is a small incidence of malignancy in prostatic utricle cysts. Recently laparoscopic resection was reported.

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Spitz Nevus

The spitz nevus is a skin lesion described during the past century. The spitz nevus is a benign skin tumor with a symmetric dome-shaped appearance ranging in color from light tan to dark brown, sometimes black. The most usual location of a spitz nevus in a child is the head and neck region. Spitz nevus are usually confused with hemangiomas early in the life of the child. Spitz nevi do not blanch on pressure, grow rapidly and most have a size of less than one centimeter in diameter. In some circumstances, unequivocal distinction

between Spitz nevus and melanoma is practically impossible. Congenital Spitz nevi are true congenital lesions, with histopathologic features of both acquired Spitz nevus and superficial congenital melanocytic nevus. Diagnosis is established by biopsy. When the diagnosis is made at age greater than 10 years, the diameter of the lesion is greater than 10 mm, presence of ulceration, involvement of the subcutaneous fat, and mitotic activity of at least 6/mm² carries a higher likelihood of malignant potential warranting aggressive surgical therapy. Due to the difficulty in diagnosis and the metastatic potential in certain spitzoid nevi it is recommended that these lesions be managed by excisional biopsy with a 1- to 2-mm margin of normal-appearing skin and long-term follow-up. Local recurrence has been seen in a few cases. Halo degeneration of spitz nevus represents lymphocytic infiltrate which permeated the full thickness of the nevus.

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Hyperhidrosis

Primary idiopathic hyperhidrosis is the occurrence of perspiration in excess of that required for body cooling. Secondary hyperhidrosis can be the result of conditions such as hyperthyroidism, severe obesity, pheochromocytoma or anxiety. Primary hyperhidrosis can involve the hands, axillae, or trunk. Sweat is secreted by eccrine glands innervated by sympathetic cholinergic fibers. Eccrine glands consist of tubules which extend deeply in the dermis becoming coiled and surrounded by myoepithelial cells. The majority of children seek help due to palmar hyperhidrosis. The condition can be socially debilitating causing psychological and emotional upset. Conservative management consists of antiperspirants, iontophoresis and systemic medication (anticholinergics). If the condition does not improve with conservative measures, surgical sympathectomy is indicated. The aim of surgery is to disrupt the sympathetic supply to palms by destroying relevant ganglions in the upper thoracic sympathetic chain (T2 and T3). The sympathectomy can be done supraclavicular, limited posterior thoracotomy, transaxillary thoracotomy or using thoracoscopy. Results are excellent. The most serious and uncommon complication is Horner's syndrome.

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ISSN 1089-7739