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Esophageal Atresia with Proximal TEF

Esophageal atresia with or without a tracheoesophageal fistula (TEF) is considered the most common congenital anomaly of the esophagus. Most cases are either esophageal atresia with distal TEF or pure esophageal atresia without a fistula. A gasless abdomen with a coiled nasogastric tube is sufficient evidence to diagnose pure esophageal atresia. Less than 1% of all cases of esophageal atresia have a concomitant proximal TEF. The presence of such anomaly can be suspected with the proximal esophageal stump is filled with air, or if a contrast proximal esophagogram is ordered and the fistulous tract identified. Intraoperatively a proximal TEF can be identified during bronchoscopy or more commonly while dissecting the proximal esophageal stump to obtain length for the anastomosis. Esophageal atresia is initially managed with a feeding gastrostomy to start gastric feeding and obtain a study to determine the gap that exists between the proximal and distal esophageal stumps. In the presence of a proximal TEF causing chronic aspiration of saliva the need for early esophageal continuity arises. The strategy can consist of ligating the TEF and doing an anastomosis under tension, bringing the proximal esophageal stump through an extrathoracic lengthening procedure or utilizing Foker technique of continuous proximal and distal lengthening with later anastomosis. In either cases the rate of ischemia, leak and stricture is high.

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Dermal Sinus Tract

Dermal sinus tracts (DST) represent incomplete disjunction of the neural tube from cutaneous ectoderm during neurulation leaving a sinus tract of cutaneous tissue attached to the nervous system. A dermal sinus tract can occur at the lumbosacral area (most common location) or less likely at the cranial end of the neural tube, frontally (frontonasal sinus tracts) or in the occiput (occipital sinus tracts). The child presents with a skin dimple,

a small dermal mass, a cutaneous hemangioma, skin tag or tuft of hair in these areas. The lumbosacral sinus tract extends through or between the laminae, penetrates the dura and ascends within the thecal sac to end on the dorsal aspect of the spinal cord at the second sacral cord level. A lumbosacral sinus tract can tether the cord, serve as portal of entry for bacteria leading to recurrent infections (subdural abscess), result in aseptic meningitis or a dermoid tumor can develop from the tract and compress the spinal cord. Lumbosacral DST can be associated with focal neurological deficit, neurogenic bladder or orthopedic deformities. The diagnosis can be established with MRI in most cases. Management is surgical excision. Simply removing the cutaneous component without addressing the spinal cord malformation is not sufficient therapy. Poor awareness leads to delayed management.

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Molluscum Contagiosum

Molluscum contagiosum is a pox viral infection affecting primarily the skin of infants, children and adults. It causes firm discrete pearly papules that measure between one and four millimeters in diameter. The papules have a characteristic central umbilication with a caseous type of material containing virus-laden cells. One-third of children have symptoms from, or secondary reactions to the infection, including pruritus, erythema and, occasionally, inflammation and pain. Molluscum contagiosum can occur singly or in clusters anywhere on the body, though the trunk is more commonly affected. Spread is usual by direct contact, with genital involvement suggesting the possibility of sexual abuse in the young child. The virus produces a number of substances that block immune response formation in the infected host. Molluscum contagiosum is a benign and self limited disease with most cases resolving within six months to one year irrespective of therapy, though patients with weakened immune systems have increased difficulty in clearing lesions. A single, most effective treatment for either infection has not been defined. Conventional methods attempt to nonspecifically destroy infected tissue. Immunocompetent children can be managed with imiquimod, retinoids, and alpha-hydroxy acids. Surgical management, if undertaken, includes curettage of the central plug, cryosurgery and/or electrodesiccation.

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