Laparoscopic Pyloromyotomy

Infantile pyloric stenosis (PS), the most common abdominal surgical condition in infancy, has been traditionally managed with an open myotomy from antrum to short of the pyloroduodenal border (Fredet-Ramstedt's) since early century with excellent results. In 1991 the suggestion that the procedure could benefit from the video-endosurgical point of view was posed. Since then a few series have retrospectively compared results between both approaches (open and laparoscopic). Major advantage of the laparoscopic technique is in wound cosmesis, a theoretical reduction in the incidence of adhesions and a reduced postoperative wound infection rate. Lap technique is more expensive given the fact on the need of video equipment, training learning curve and operating time. The most dreaded complication is duodenal perforation during the procedure since this changes the morbidity and hospital stay. Difficulties in detecting this complication represent a serious limitation of the lap approach emphasizing the need to inject air through a nasogastric tube to check for leaks. Mucosal perforation is a reason for conversion to the open technique. The number of days spent in the hospital is similar with both techniques. Circumbilical open incisions have similar cosmetic results, but can be associated with problems of tumor delivery, more gastric manipulation (atony) and a higher infection rate.

References

Gastroschisis with Intestinal Atresia

Gastroschisis is a congenital evisceration of part of the abdominal content through an anterior abdominal wall defect found to the right of the umbilicus. The protruding gut is foreshortened, matted, thickened and covered with a peel. In a few babies (4 to 23%) an
intestinal atresia (IA) further complicates the pathology. IA complicating gastroschisis may be single or multiple and may involve the small or large bowel. The IA might be the result of pressure on the bowel from the edge of the defect (pinching effect) or an intrauterine vascular accident. Rarely, the orifice may be extremely narrow leading to gangrene or complete midgut atresia. In either case the morbidity and mortality of the child is duplicated with the presence of an IA. Management remains controversial. Alternatives depend on the type of closure of the abdominal defect and the severity of the affected bowel. With primary fascial closure and good-looking bowel primary anastomosis is justified. Placement of a silo calls for delayed resection performing a second look operation at a later stage to save intestinal length. Angry looking dilated bowel prompts for proximal diversion, but the higher the enterostomy the greater the problems of fluid losses, electrolyte imbalances, skin excoriation, sepsis and malnutrition. Closure of the defect and resection with anastomosis two to four weeks later brings good results. Success or failure is related to the length of remaining bowel more than the specific method used.

References

Breast Rhabdomyosarcoma
Breast rhabdomyosarcomas are more commonly metastatic with primary tumors originating in many possible locations (head, neck, orbit, trunk, extremities, buttock, genitourinary system, retroperitoneum, mediastinum, heart, gastrointestinal tract and perianal region). Primary breast location is extremely rare. World review of 26 cases found four of these patients to be younger than age sixteen. There are several reports of breast rhabdo in which a breast mass is the sole presentation of an occult primary tumor. The tumor commonly shows as a palpable, rounded, movable mass with no skin involvement but rapid increase in size. Management must be governed by the principles used for rhabdomyosarcoma that include wide local excision of the primary lesion and multiagent chemotherapy. Few studies report a familial distribution of certain cancers conforming to the Li-Fraumeni syndrome related to a genetic defect on the p53 gene locus.

References

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