# Paediatric Surgery

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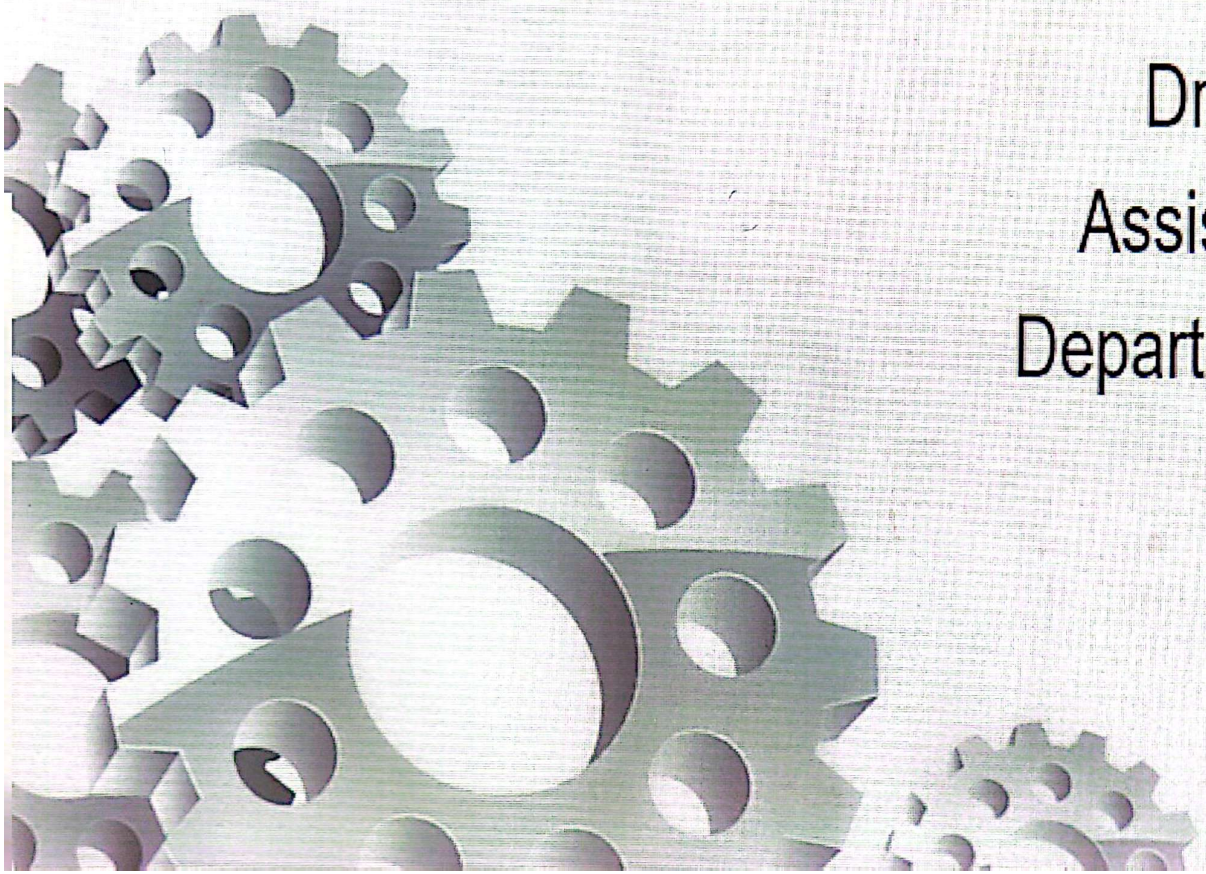


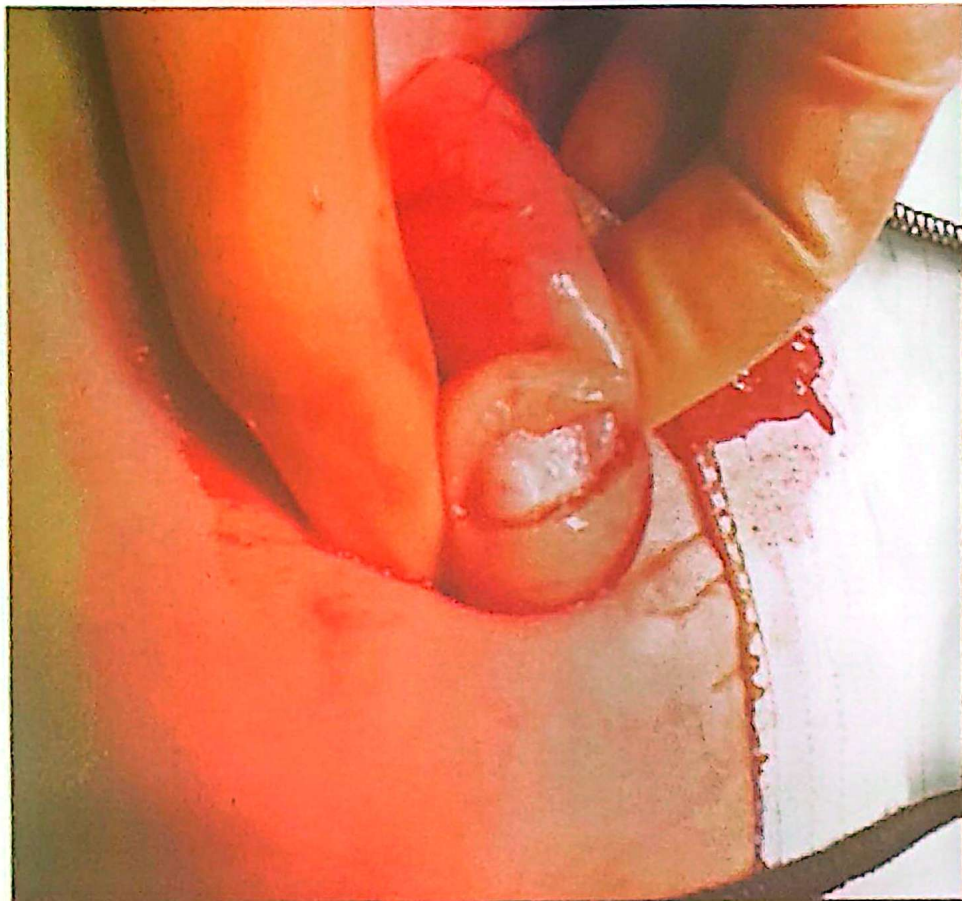
# Infantile Hypertrophic Pyloric Stenosis

- Age group -2 to 6 weeks of age
- Presentation - Non bilious projectile vomiting

once vomiting starts its forcefulness & frequency increases daily distinguishing from gastro esophageal reflux.

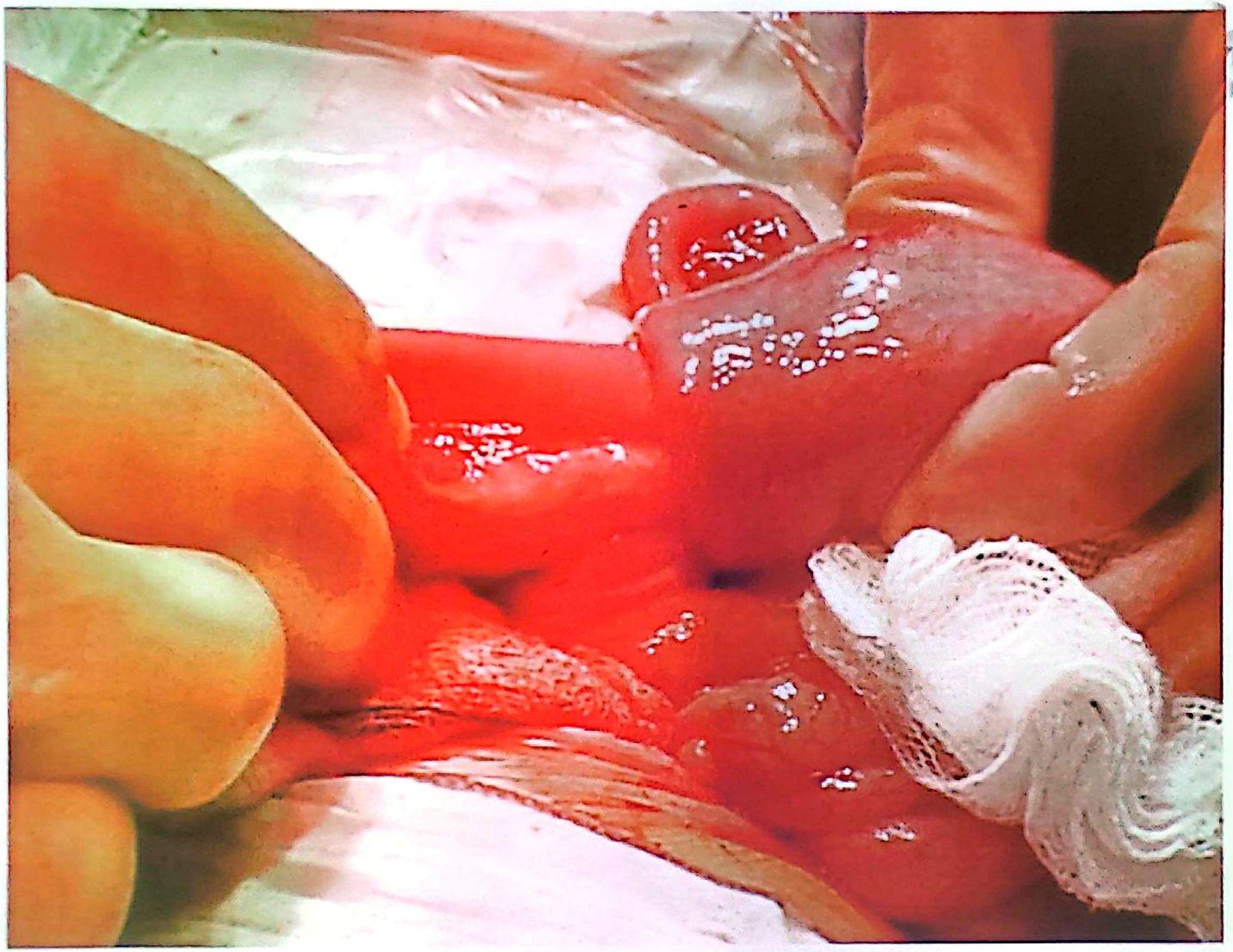
- M:F ratio 4:1
- If late presentation Weight loss & Dehydration predominate.
- The diagnosis is made on a test feed
- Abdominal USG-showing Thickened & Lengthened Pylorus.
- Treatment -Ramstedt's Pyloromyotomy

- In a test feed,Gastric peristalsis is seen passing from left to right across the abdomen
- In a relaxed (feeding) baby,the pyloric tumor is palpable as an olive in the right upper quadrant.



# Intussusception

- Age group - 2 months to 2 years
- More than 80% are iliocolic.,beginning proximal to the ileocaecal valve with an apex in the ascending colon or transverse colon.
- Stangulation can progress to gangrene & perforation
- The lead point is commonly viral induced hyperplasia in the peyer's patch,few have a pathological lead such as a Meckel's diverticulum,Duplication cyst or small bowel lymphoma.
- Presentation-Colicky pain,Vomiting and drawing up their legs.Between episodes they initially appear well.
- Later they may pass a Redcurrent jelly stool.



- Signs -Dehydration

  Abdominal distension

  A palpable Right upper quadrant mass

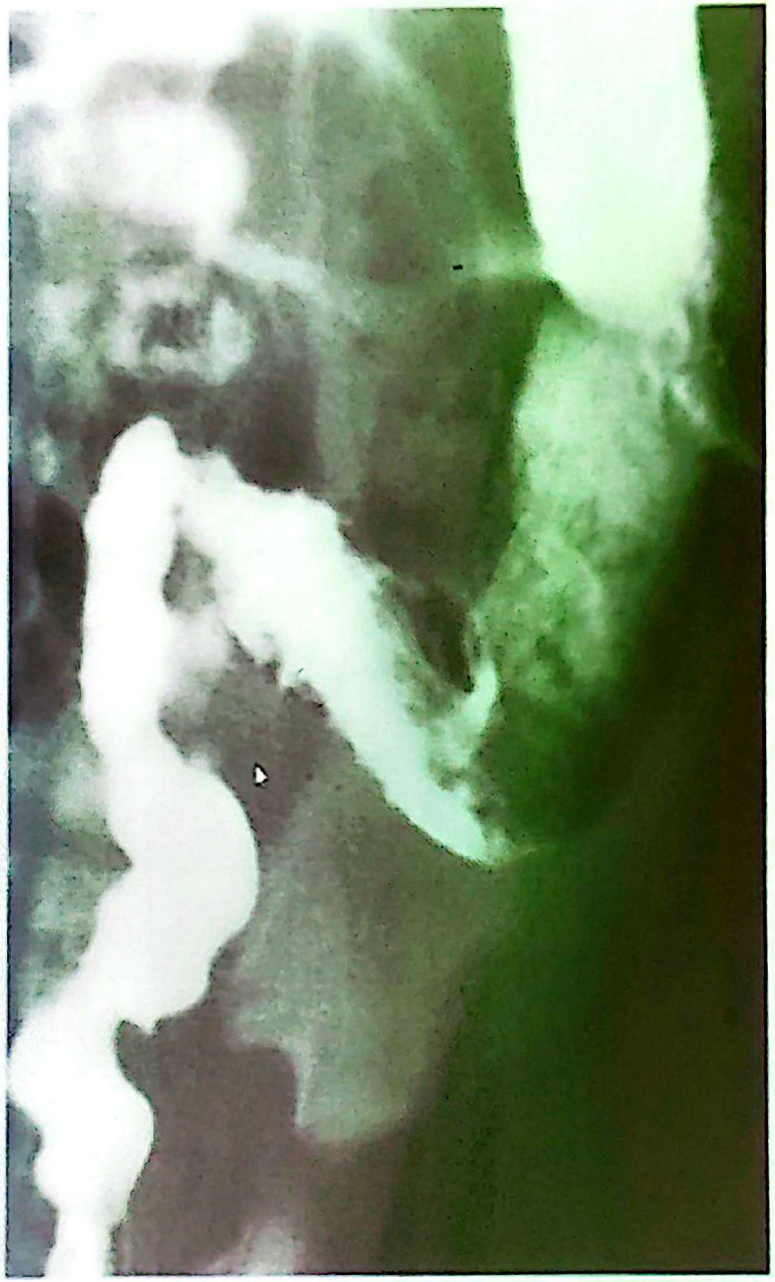
- Investigations-
- A plain Xray shows small bowel obstruction ,a mass & a paucity of gas in the right iliac fossa.
- Abdominal USG-A Concentric target sign is seen.
- Treatment- An air reduction enema is attempted after resuscitation with IV Fluids,Bread Spectrum antibiotics and nasogastric drainage.

- An air enema is contra indicated if there is peritonitis,perforation & shock.
- Operative reduction is performed open or laparoscopically.
- An irreducible intussusception or one complicated by infaction or a pathological lead requires resection.

# Hirschsprung's disease

- Presentation-Delayed passage of meconium
  Abdominal distension
  Bilious vomiting
- Cause-Genetic defects (RET,EDN3) affect migration of neural crest derived intestinal neurones,leading to aganglionosis and thickened nerve trunks in the distal bowel.
- Aganglionic bowel fail to relax causing a functional obstruction.
- Aganglionosis extends from anus to sigmoid colon in 75% ,the proximal colon in 15% and the terminal ileum in 10% cases.

- A tansition zone lies between dilated proximal normal bowel & narrow distal aganglionic bowel.
- The diagnosis is made on cot side suction rectal biopsy.
- Investigations-
- A contrast enema -narrow aganglionic segment ,a cone & Dilated proximal bowel.
- Daily rectal wash out may allow a period of growth at hme before surgey.



- Definitive surgery -Remove Aganglionic segmentand bring ganglionic bowel to the anus
- Mathods-Swnson,Duhamel,Trans anal pull through