Case Discussion

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2013 / 01 / 02

Case 1

- 13-yo Male BW: 45 kg
- DAY1 16:35 pm
- C/C: **Epigastric pain since this morning**
- TPR: 36.5/94/18 BP:133/83
  SpO2: 100% GCS: 15
- Triage: 2

Present Illness

- Sudden-onset (3-pm),sharp pain; radiation(-), postural related (-)
- Nausea (+), Vomitus (-), Diarrhea (+) [twice; mucoid/bloody(-)] , Loss-of-appetite (+) [lunch(-)]
- NO fever/chillness, URI, trauma, dyspnea, cold-sweating

History

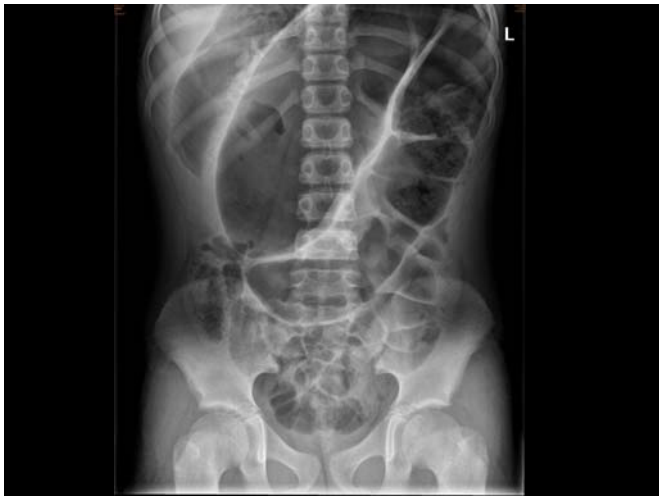
- Medical
  - Frequent constipation (infant → elementary school); Daily defecation in recent 2 years
    - Manometry (2004/06)- WNL of int. sphincter
  - (12/19): AGE
- Surgical: DENIED
- Allergy: NIL

Physical Examination

- Chest: Clear breathing sound
- Abdomen:
  - **Distended above umbilicus**; Epigastric tenderness
  - Hyperresonance-on-percussion
  - No rebounding pain or muscle guarding
- Extremities: Warm

Impression

- Acute gastroenteritis
- Ileus/ Bowel obstruction



Abdominal CT

OP Finding

- Serous ascites: 100 ml
- Redundant sigmoid colon (20 cm) with 180-degrees rotation
- No ischemia or gangrenous change

Discussion

- 40~70% of colonic volvulus
  - Cecum > T-colon & splenic-flexure
- Elderly, institutionalized, debiliated (parkinsonism, schizophrenia) patients
  - Colonic dysmotility

Discussion

- RARE in young children or adolescent
  - Delayed diagnosis due to atypical age
- Initial presentating feature of Hirschprung's disease
  - *J.Pediatr Surg. 1997;32(1):117*

檢查項目 (1) 4591020 (2) 4591040 (3) (4) (5)
診斷代號 (1) T0-0 (2) (3) (4) (5)
檢體 : TI Tissue 結果 :S T 0 C Q Y 報告說明 :

行 內 容
021 : Representative sections are taken and labeled as follows:
022 : A: Vermiform appendix, B: Sigmoid colon.
023 :
024 : MICROSCOPIC DESCRIPTION:
025 : Section of the specimen labeled as "Vermiform appendix" shows no ob-
026 : vious evidence of transmural acute suppurative inflammation. The mu-
027 : cosa is intact. The mesoappendix reveals congestion.
028 : Section of the specimen labeled as "Sigmoid colon" shows a piece of
029 : smooth muscle coat. No obvious ganglion cell can be found.
030 :

Complications of Hirschsprung Disease

- **Acute intestinal obstruction (neonate)**
  - **95% failure to pass meconium**
- **Enterocolitis**
  - **Pre-, Immediate, and Post-operative**
- **Volvulus**

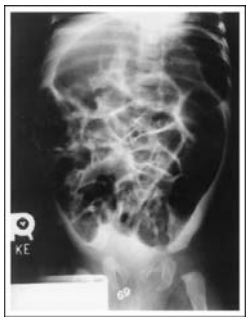
Hirschsprung-associated enterocolitis (HAEC)

- Explosive foul-smelling diarrhea, fever, vomiting, abdominal pain and distension

Grade	clinical symptoms
I	Mild explosive diarrhea; mild or moderate abdominal distension; no systemic manifestations
II	Moderate explosive diarrhea; moderate to severe abdominal distension; mild systemic symptoms
III	Severe explosive diarrhea; marked abdominal distension; shock or impending shock

Radiographic Finding

- Proximal colon distension
- "Cut-off sign"



Pathogenesis

- Bacterial overgrowth in bowel-lumen
  - Stasis & ↓ protective mucin
  - ↓ (bifidobacteria and lactobacillus)
  - ↑ pathogenic bacteria (C. difficile, S.aureus)

Treatment

- IV-antibiotic
  - Aerobic & anaerobic
- **Rectal irrigation**
- (Pre-OP) Diverting colostomy

Case 2

- 1Y11M Male
- DAY1
- C/C: **Fever for one day**

Present Illness

- Intense **dry cough** since 4-pm yesterday evening
  - post-tussive vomiting
  - meal-intolerance
- Fever up to 39 degrees around 11-pm
- **DENIED** rhinorrhea, GI-upsets, diarrhea, turbid urine, skin rashes

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Physical Examination

- TPR: 37.7/**158**/30, BP:105/89, SpO_2:95%(RA)
- HEENT : Injected throat
- Chest : **↓ right breathing sound**
  No stridor or wheezing
  : No accessory muscle use or nasal flaring
- Abdomen: Soft and flat without tenderness

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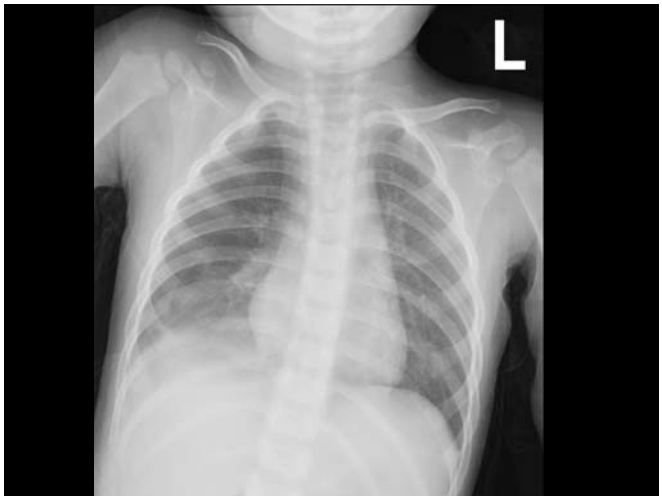

Tentative Diagnosis

- ????

Present Illness

- Preceding **choking** episodes

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Discussion

- Life-threatening emergency
- 1~3 years old
  - ↑ mobility and oral exploration

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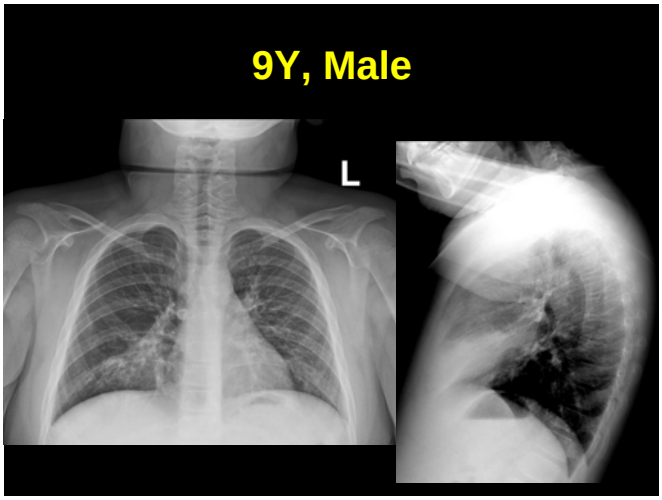
- Consider foreign body aspiration in a young child with respiratory symptoms, **regardless of the duration**
  - Many children may present **>24 hours** after foreign body aspiration**.**
- History of **sudden** coughing and choking
  - most predictive of all signs and symptoms

- Classical dogma
  - Laryngotracheal: Stridor, hoarseness
  - Bronchial: Unilateral wheezing
    ↓ Breath sounds

Radiography

- Radiographs are helpful to ***confirm*** the diagnosis of airway foreign body
  - **NOT to exclude** the diagnosis,
    - > 50% of tracheal foreign bodies
    - ¼ of bronchial foreign bodies ***<NORMAL>***
- > 75% of airway foreign bodies are radiolucent in children < 3-yo



Radiography

Indirect Signs

- Unilateral obstructive emphysema
  - Check-valve obstruction
  - Inspiratory-**expiratory** films: Air trapping
- Atelectasis
- Consolidation

Disposition *at SKMH*

- Consult ENT
- **Transfer**

Case 3

- 8Y11M Male BW: 30 kg
- DAY1 09:24 pm
- C/C: **Left side weakness since this morning**
- TPR: 35.5/127/20 BP:127/75
  SpO2: 99% GCS:E3V3M4
- Triage: 2

Present Illness

- Sudden onset (? time) shouted abruptly
- Vomitus with left side weakness and consciousness-change
- DENIED trauma, seizure, drug history

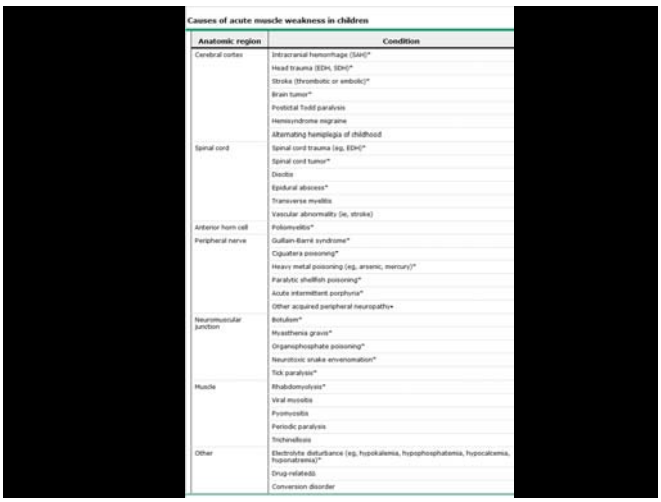
History

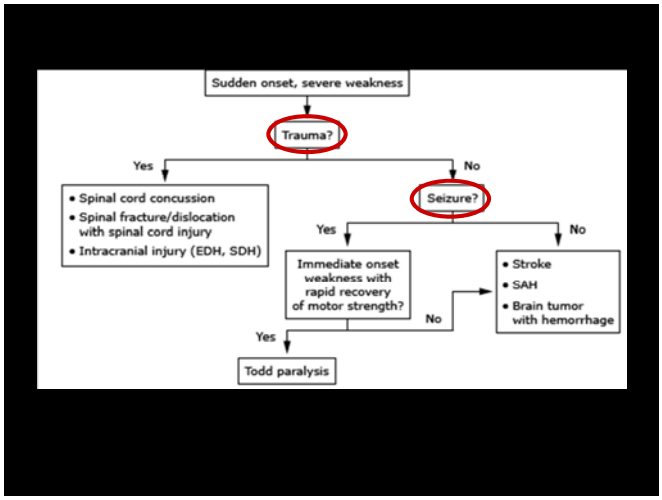
- Medical: Autism
- Surgical: DENIED
- Allergy: NIL

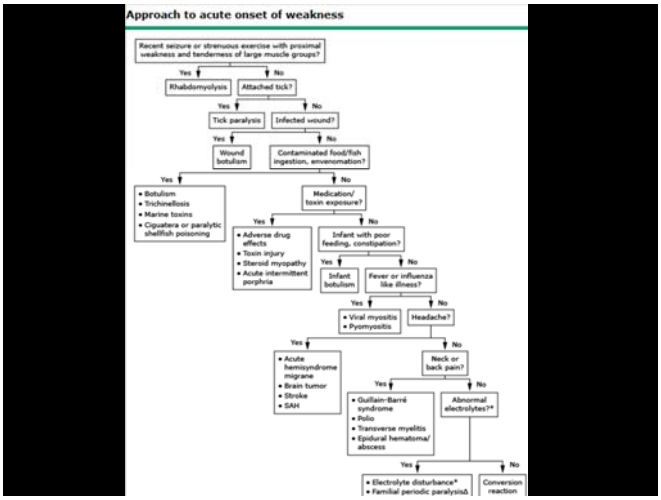
Physical Examination

- Pupils: 3+ / 5+; Neck: Supple
- Chest: Clear breathing sound
- Abdomen: Soft, flat
- Muscle power
  - R/L: 5/2
  - Babinski: Negative over left side

Brain CT







Guillain-Barre Syndrome

- Preceeding URI or AGE (2~ 4 weeks)
- Acute, progressive, **symmetric**, ascending weakness *(gait-difficulty)*
- ↓ DTR or absent
- Neuropathic pain, but **min. sensory loss**
- Sensory dysfunction, ophthalmoplegia, ataxia & bulbar dysfunction (Miller-Fisher Syndrome