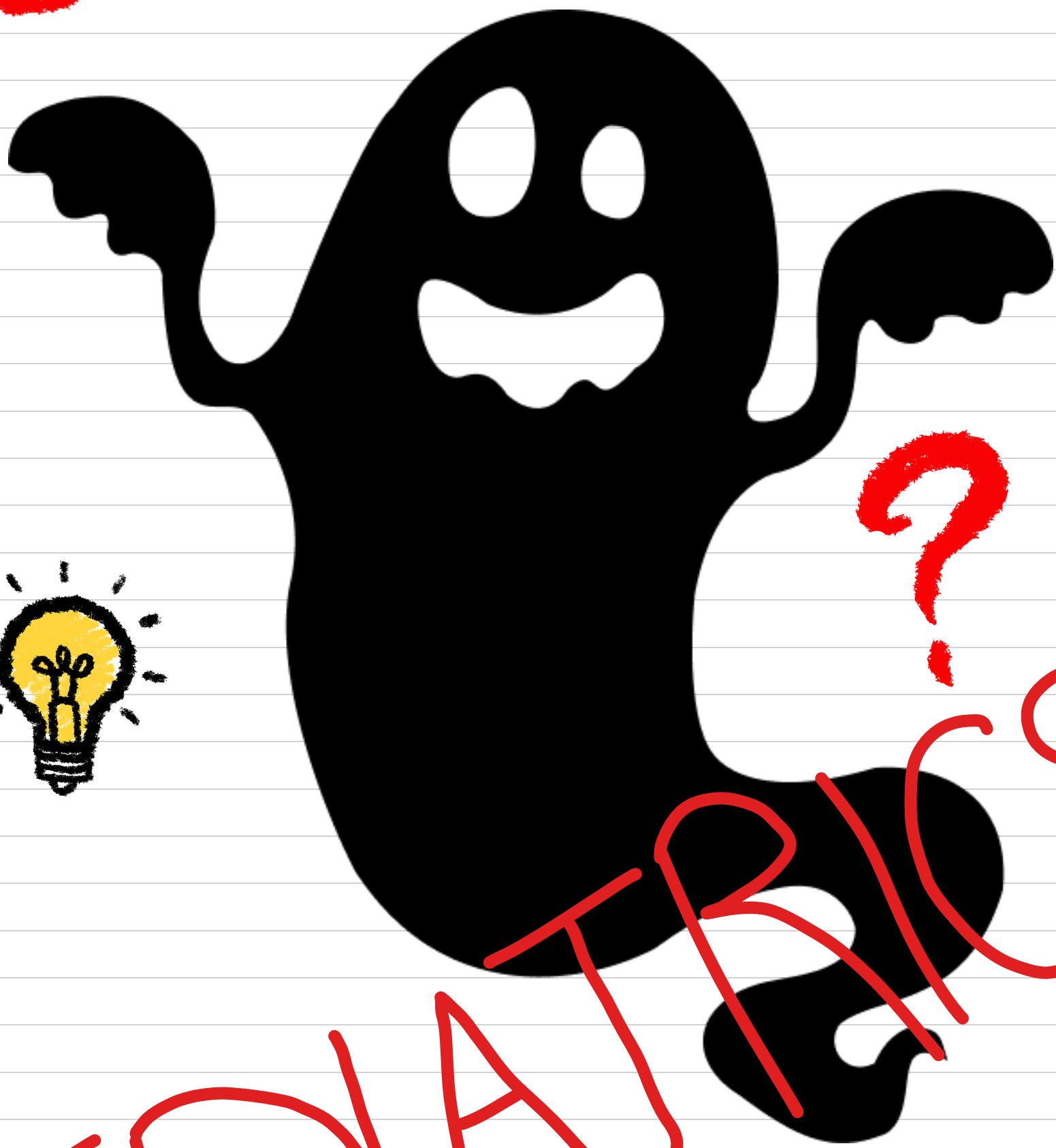
دعواتكم



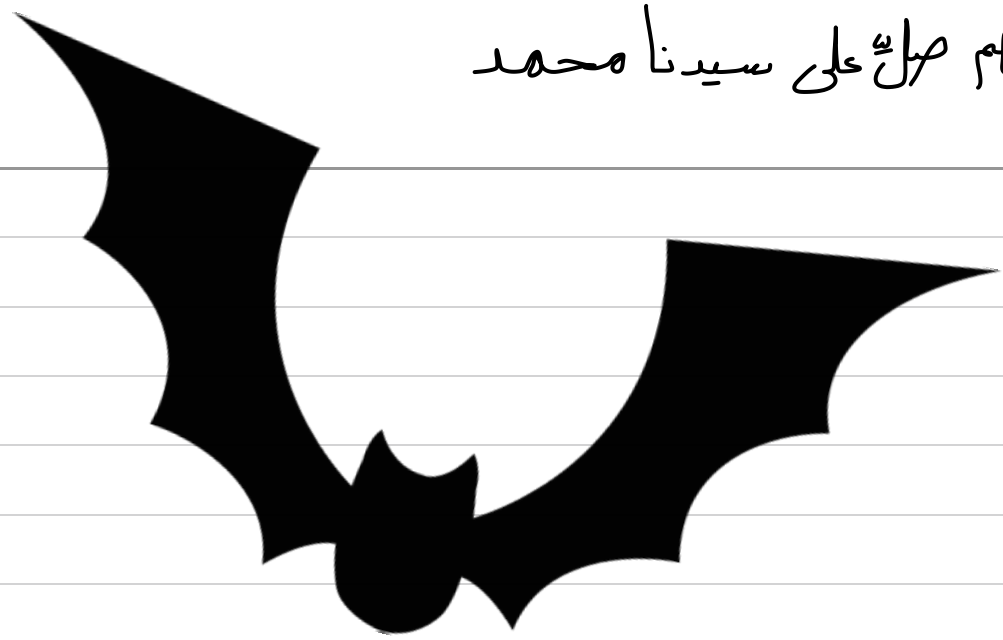
PEDIATRICS

لا تنسونا من دعواتكم !!

الكاتبة : سارة جمال

بالتوفيق جميعا

اللهم صل على سيدنا محمد



Ingestion/Aspiration of FB

→ **esoph. FB**

* more in ≤5y
* Us → coins
  marine areas → fish bone
* eso is the narrowest portion of GI tract.
* 3 areas of narrowing
  ① circopharyngeus sling (70%)
  ② Level of the aortic arch in the mid esoph.
  ③ LES (GE Junction)
* other areas: 1) underlying eso. patho (strictures → caustic ingestion or esinophilic esophagitis)
  2) prior eso surgery (eso artesia)

* sharp FB may pentrate the mucosa and cause:
  ① mediastinitis
  ② aortoenteric fistula
  ③ peritonitis

Hx: → witnessed event or disappear of an object.
Symp can vary:
→ completely asymp
→ drooling
→ neck and throat pain
→ dysphagia
→ emesis
→ wheezing or RS distress
→ abd pain.

PEx:
* majority → normal
* signs of CX:
  ① oropharyngeal abrasions
  ② crepitus
  ③ signs of peritonitis.

Management:
① Neck + chest X-ray
② ± contrast esophagography
③ ± esophagoscopy

Foley catheter technique
* the balloon filled with contrast
* under fluoroscopy
* care to avoid aspiration
* very cost-efficient.

Coins: * most located in the proximal esophagus.
* majority of proximal will remain entrapped and require retreival → options:
  ① megal forcep
  ② endoscopy (rigid or flexible)
  ③ foley balloon extraction with fluoroscopy (80% success)

* if reached Lower esophagus
  ↳ can spontaneously pass into stomach
  ↳ can be observeed
  ↳ can be advanced into the stomach with (NGT in ER)

→ Gastrointestinal FB

* if distal to eso. usually asymptomatic → most pass smoothly through GI tract out through anus
* signs and symp: → ex. in stomach
  - abd pain
  - nausea / vomiting
  - Fever
  - abd distention if intest. obst.
  - peritonitis if perforation

Mx: ① can be managed as an outpatient
② ? prokinetic agents and cathartics
③ if didn't pass → endoscopy (for 4-6 wks)
④ Laparoscopy [from jejenum to terminal ileum → non reachable nither by endoscopy nor colonoscopy]

Special topic Ingestions:

1 Batteries:

* mostly asymp, symp just in <10%
* on radiographs: double contour rim
* problem → contact time btw the battery and eso. bc narrow
* tissue injury → pressure necrosis
  → relase of low-voltage electric current
  → Leakge of alkali solution (liquefaction necrosis)
* mucosal injury may occure in 1 hour of contact time and may continue even after removal.
* Immediate removal
* early and late Cx:
  - esophageal perforation
  - tracheoesophageal fistula
  - stricture and stenosis
  - mortality

* if the battery is confirmed to be distal to the eso AND the pt is asymptomatic → observe

2 MAGNETS

* Sig morbidity if ① multiple magnets
② single magnet + sec metalic FB

if 2 connected magnets swallowed togther → not major problem but if seprated → if 2 diff areas in GIT → pressure necrosis → perfo, fistula, stricture .....

* m.c symp is abd pain
* <40% symp
* plain radiograph (m.commonly used to confirm diag)
* Mx: * close inpatient observation (if 2 magnets or 1 + metallic FB or if in doubt)
  * outpatient observation (if 1 magnet)

* they may attach to each other and lead to: obstruction, volvulus, perforation, fistula.

Sharp foreign bodies
* 15-35% risk of perforation
* Mx: * conservative: smaller objects and straight pins.
  * endoscopic retrieval
  * close inpatient observation

Bezoars: is a tight collection of undigested material
* include
  - Lactobezoars (milk)
  - phytobezoars (plant)
  - trichobezoars (hair)

* presenting symptoms: nausea / vomiting / weight loss / abd distention
* Diagnostic imaging: plain radiographs, upper GI contrast, endoscopy.
* Mx: operation is necessary (phyto + tricho)

- phytobezoar → * vegetable matter
  * usually obst at the ileo-cecal valve level
- Trichobezoar → * hair
  * Rapunzel syndrome (stomach ts. bowel) asso with trichotillomania
  * tipically removed by gastrotomy + Laparatomy + Laparoscopy

→ Airway FB:
* anatomical diff in airway of young children compared with older children
  - ↳ shorter airway / smaller in calibre
  - ↳ anteriorly positioned Larynx (↑ difficulty with oral intubation)
  - ↳ Subglottic region is the narrowest part

Fixed right main stem bronchus:
- Larger in diameter
- airflow is generally greater
- smaller angle of divergence from the trachea

* high index of suspicion is required.

*common presenting symp:

① RS distress

② stridor * inspiratory → Laryngeal FB
* expiratory → tracheal FB

③ wheezing

④ Dysphonia

*many will be asymp

* may completely obstruct the Larynx or trachea producing sudden death.

* Ap + lateral films of the neck and chest (inspiratory and expiratory)

* hyper inflation or "air trapping" ± mediastinal shift

*5%: → normal chest film in 24 of aspiration

* radiopaque FB are easily identified

* radiolucent FB → indirect clues.

* definitive Dx requires Bronchoscopy → flexible → to diagnose
→ rigid → diag + therapeutic

* Fogarty catheter

- Overall **complications** of rigid or flexible bronchoscopy:

* • Bleeding from local inflammation
* • Laryngospasm
* • Pneumothorax
* • Hypoxia

- Rarely a thoracotomy with bronchotomy or lobectomy is required. if bronchoscopy isn't beneficial