COMMON PS CONDITIONS – WHEN TO REFER

Ellen Mapunda

PAEDIATRIC SURGERY

Charlotte Maxeke Johannesburg Academic Hospital

Generalist. Specialist. Subspecialist.

Abscess Labia fusion Reflux PDA Burns
Testicular torsion Foreign body aspiration
Appendicitis Midgut volvulus Circumcision
Abdominal pain Anorectal malformations
NEC Ranula Tongue tie Diaphragm hernia
Vascular access Animal bites
Intussusception Foreign body ingestion
Duplication cyst
Congenital Bowel atresias Abdominal mass
Inguinal hernia Hirschprung's disease
Undescended testes Acquired Oesophageal atresia
Head and neck lumps and bumps Umbilical hernia
Ovarian torsion Congenital lung lesions
Caustic ingestion

Head & Neck, Chest, ABDOMEN, Genitourinary

Neonate to 16years

- ✓When you see it
- ✓When you suspect it
- ✓When you diagnose/confirm it
- ✓When in doubt
- ✓As soon/early as possible

- ✓When it is not responding to medical Rx

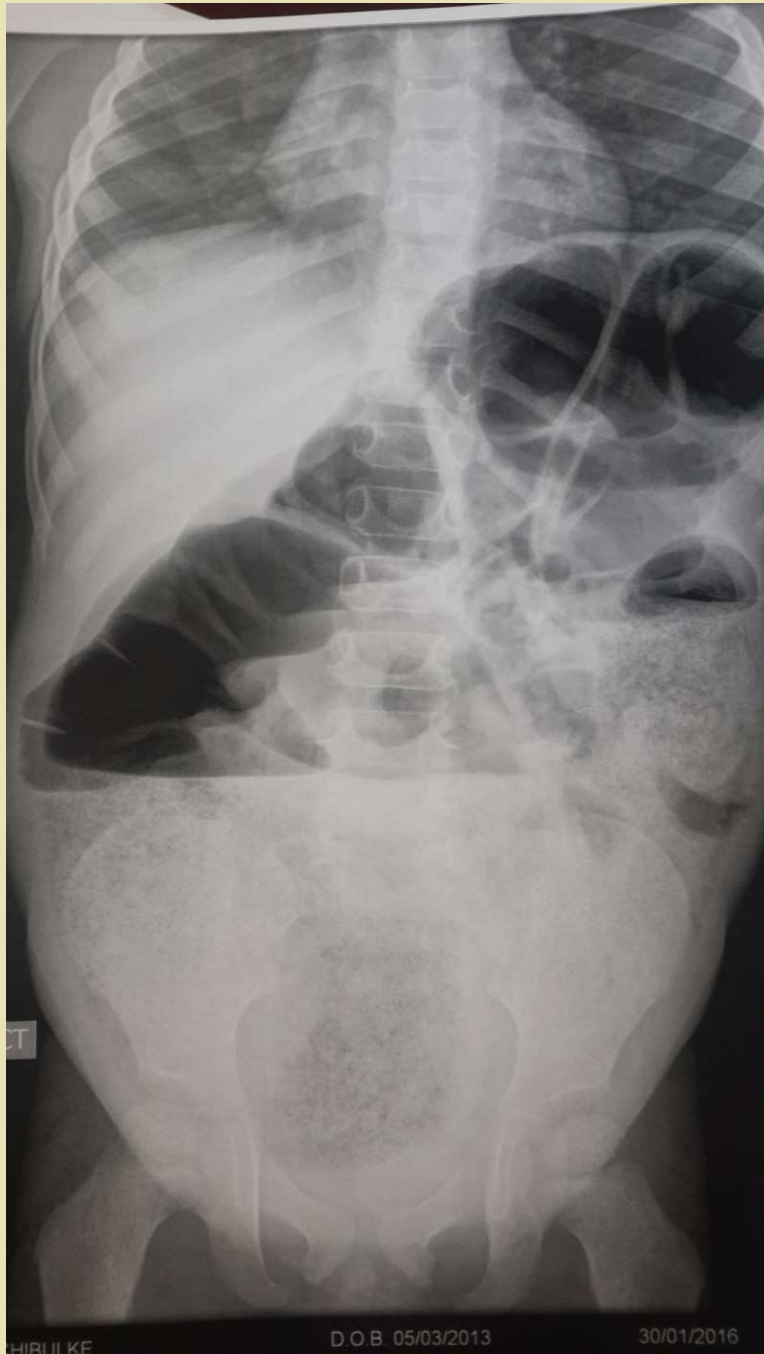
- REFERRAL TO INVESTIGATIONS

- Low threshold for imaging
- Plain X-rays and ultrasound
- Baseline bloods

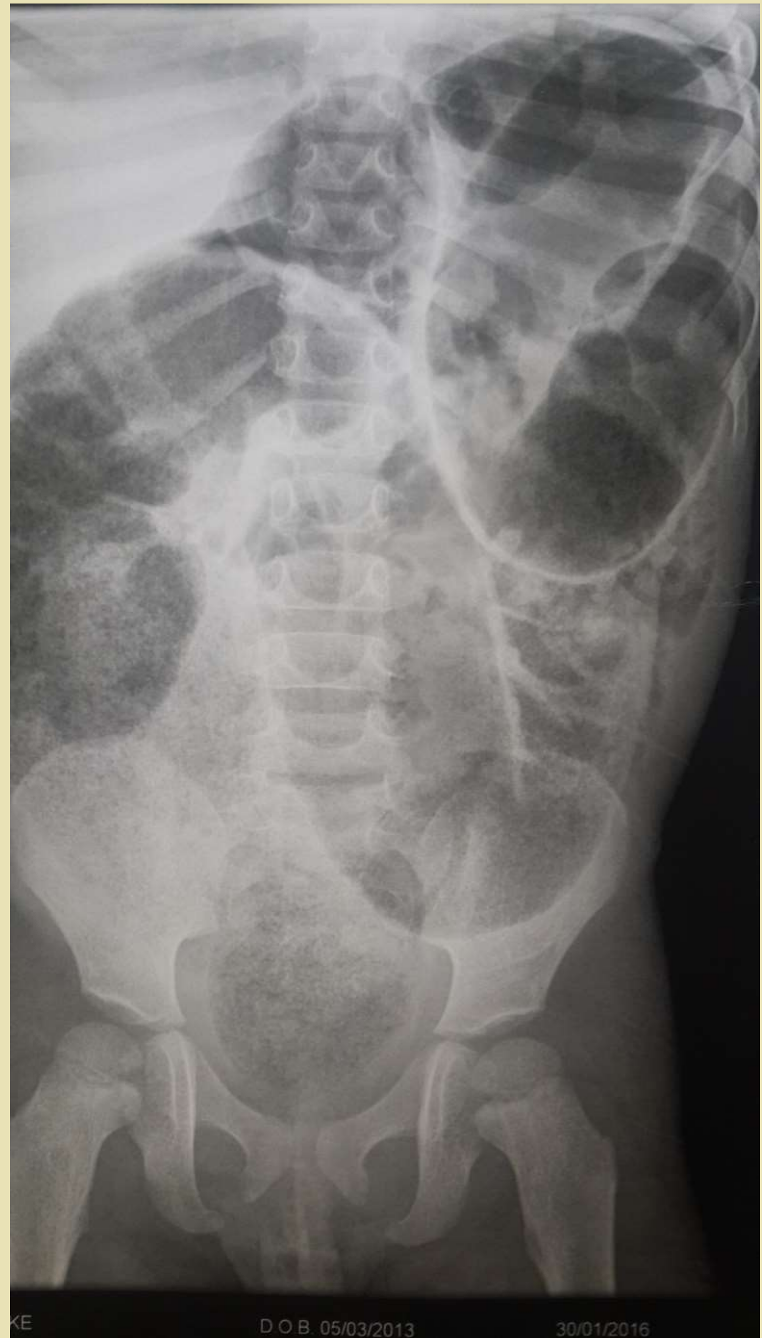
The Abdomen/GIT

- Increased Girth
- Distension
- Mass
- FTT
- Vomiting
- Dysphagia

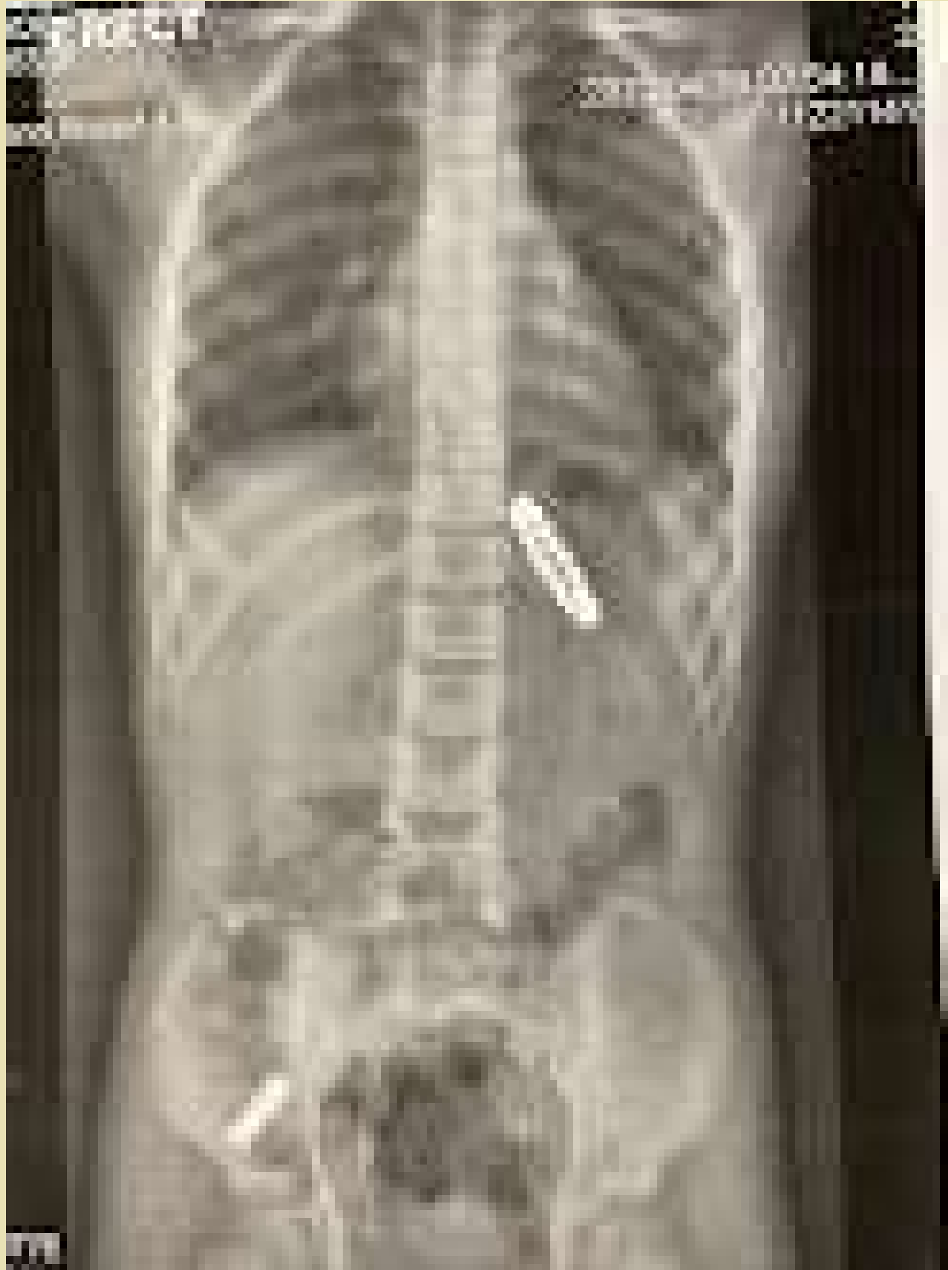
?Basic/baseline inventigations

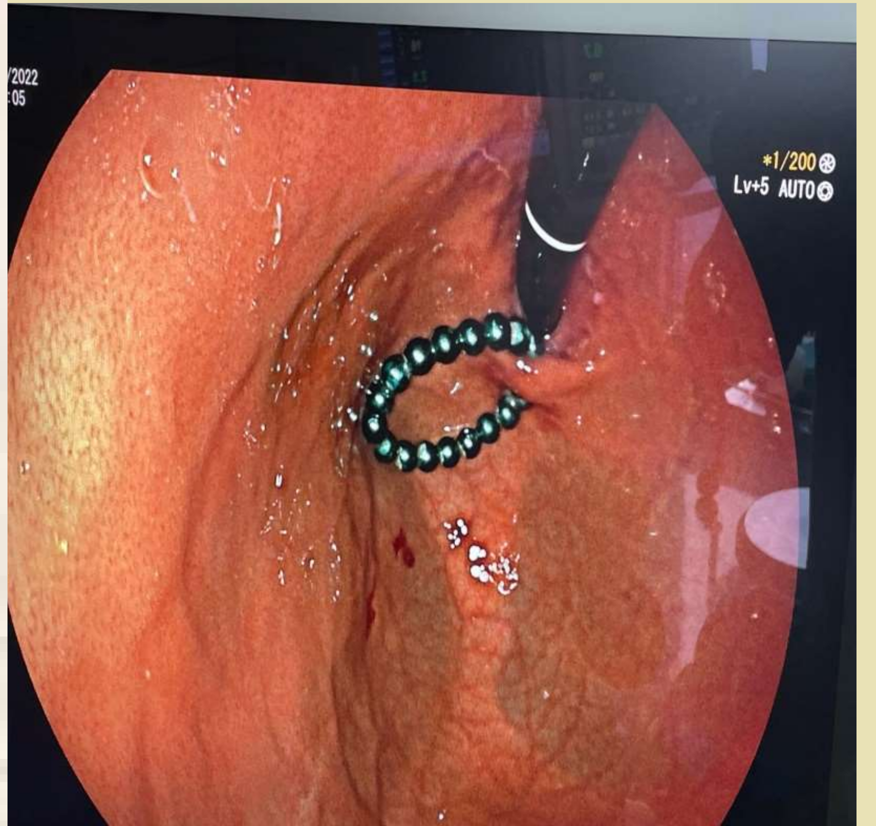


D.O.B. 05/03/2013
30/01/2016



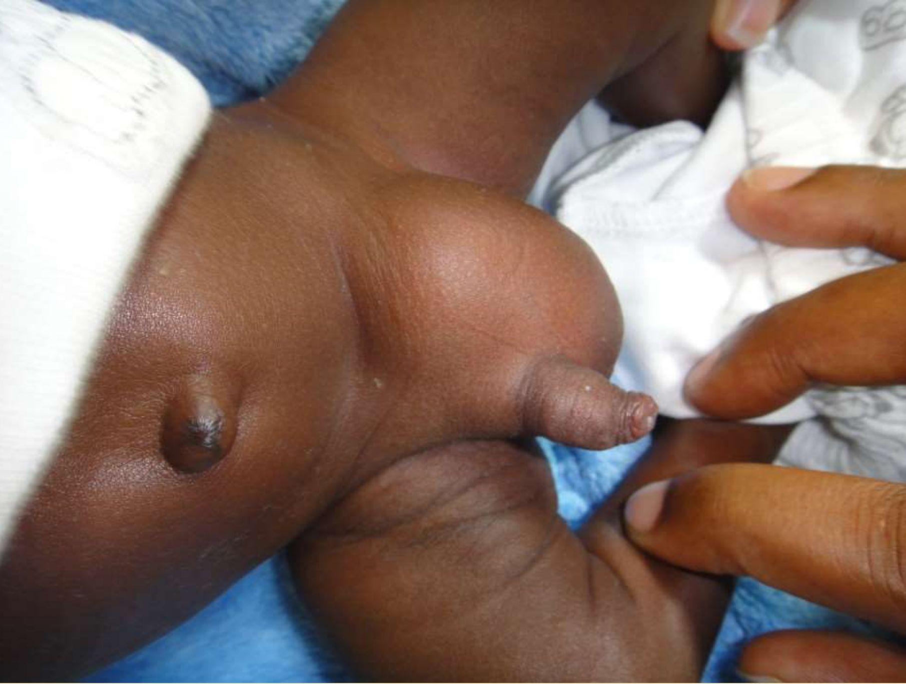
D.O.B. 05/03/2013
30/01/2016

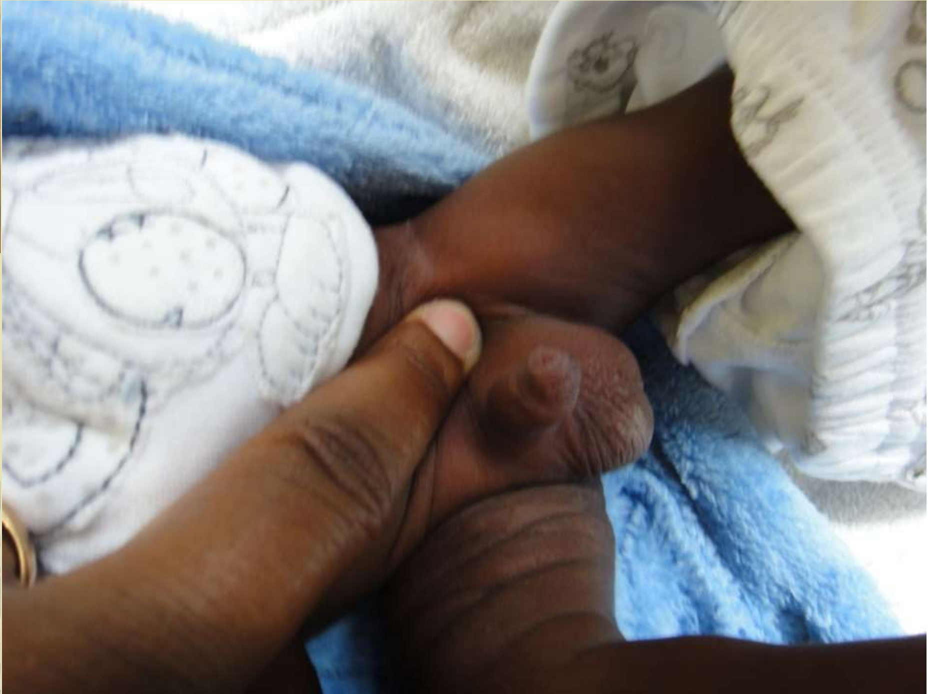


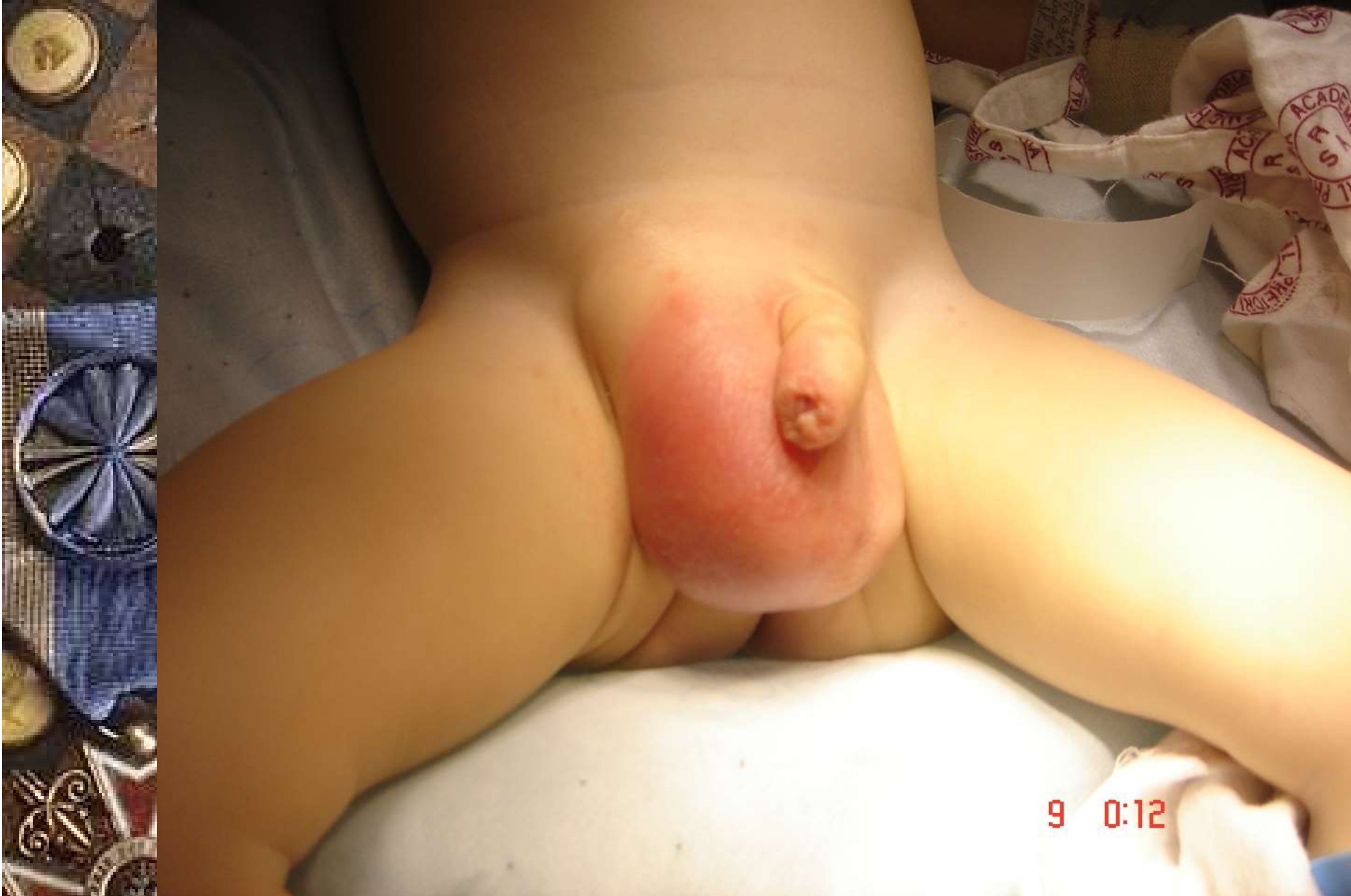
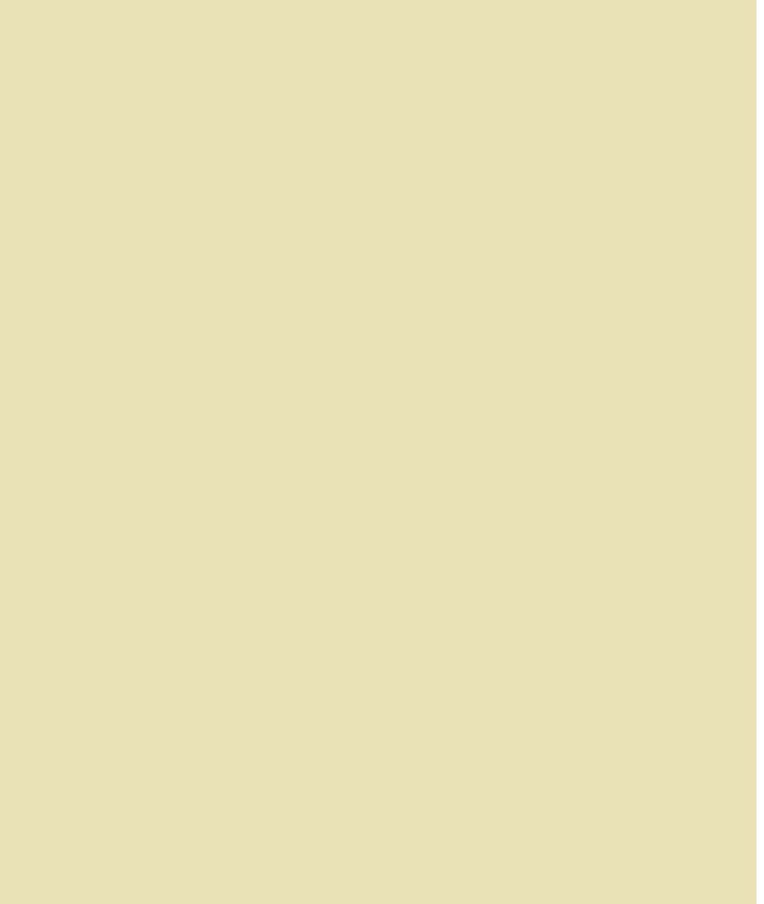

/2022
*1/200
Lv+5 AUTO

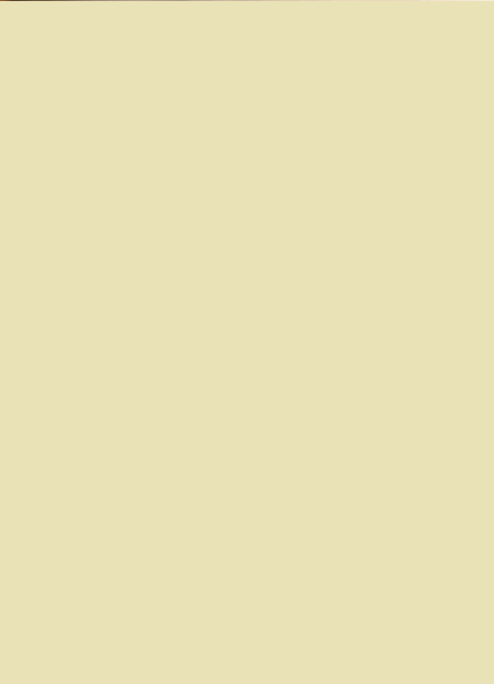
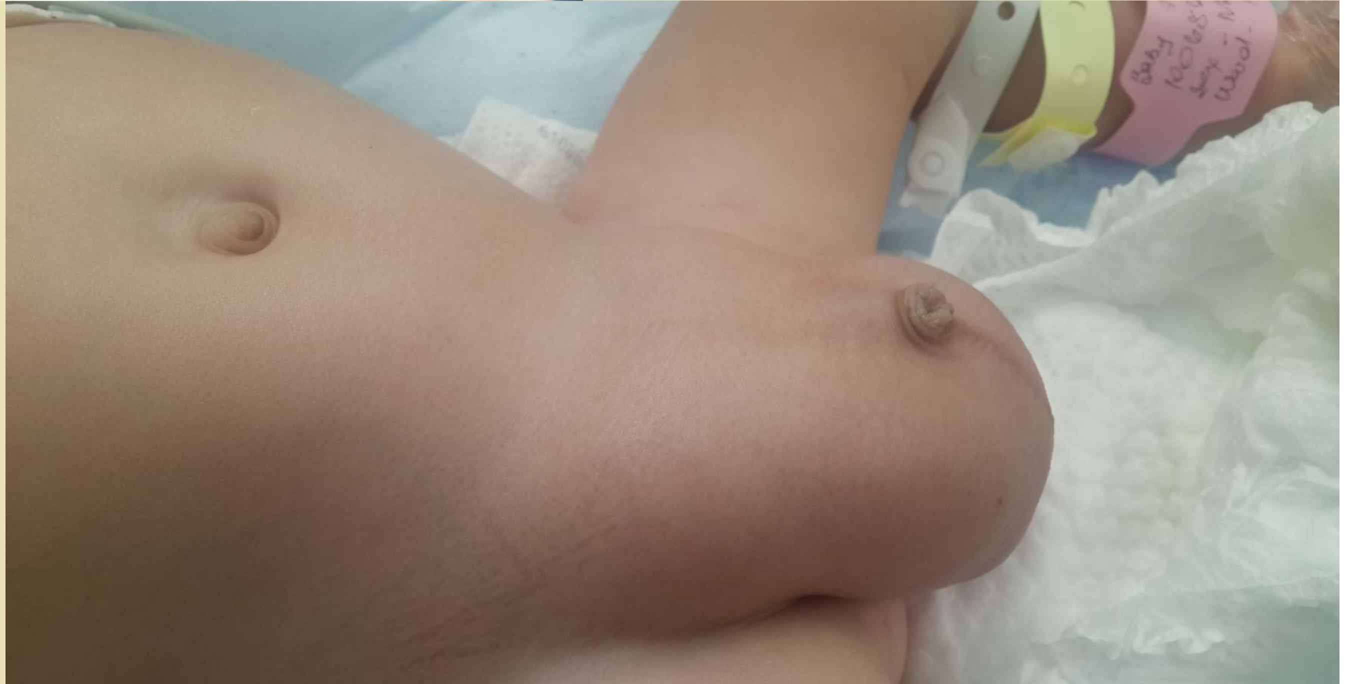
Inguinal hernia

- As soon as diagnosed
- History alone is adequate
- Clinical diagnosis



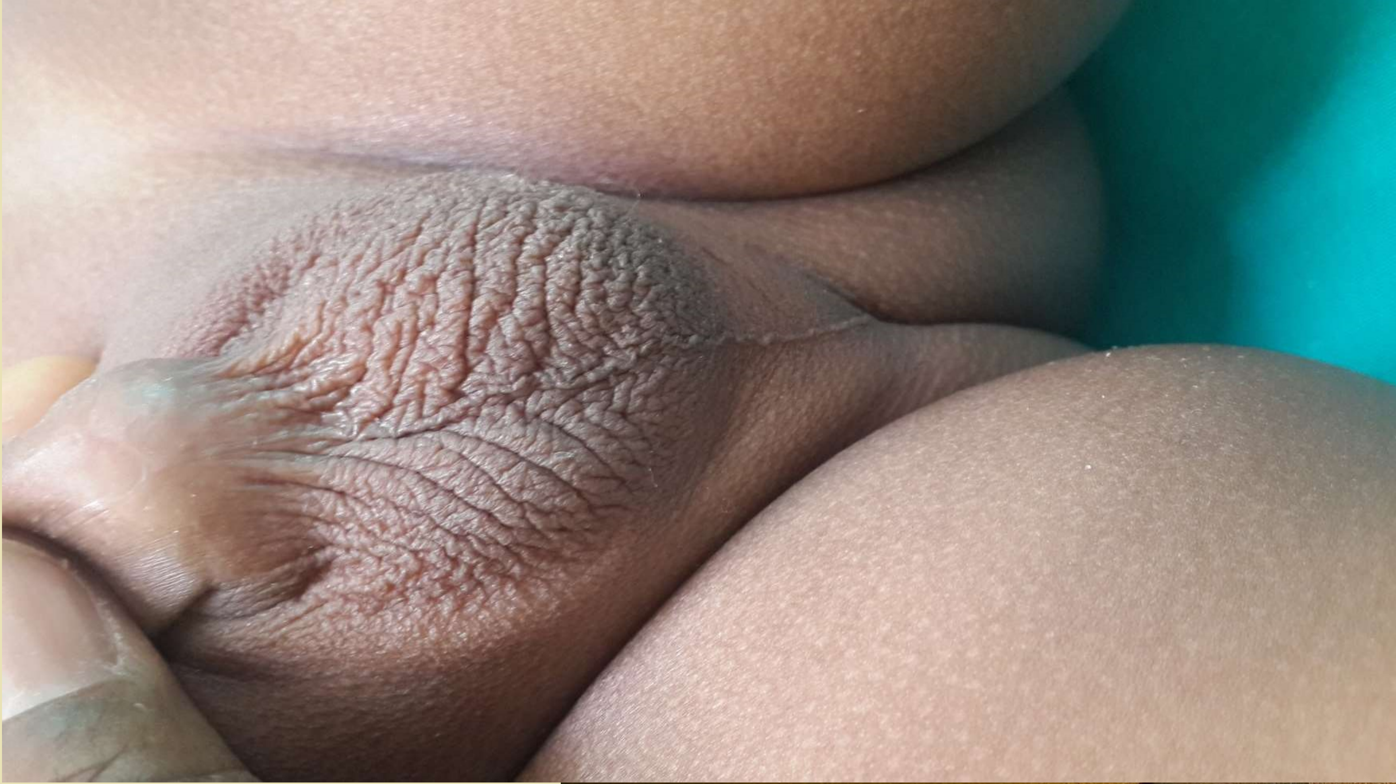


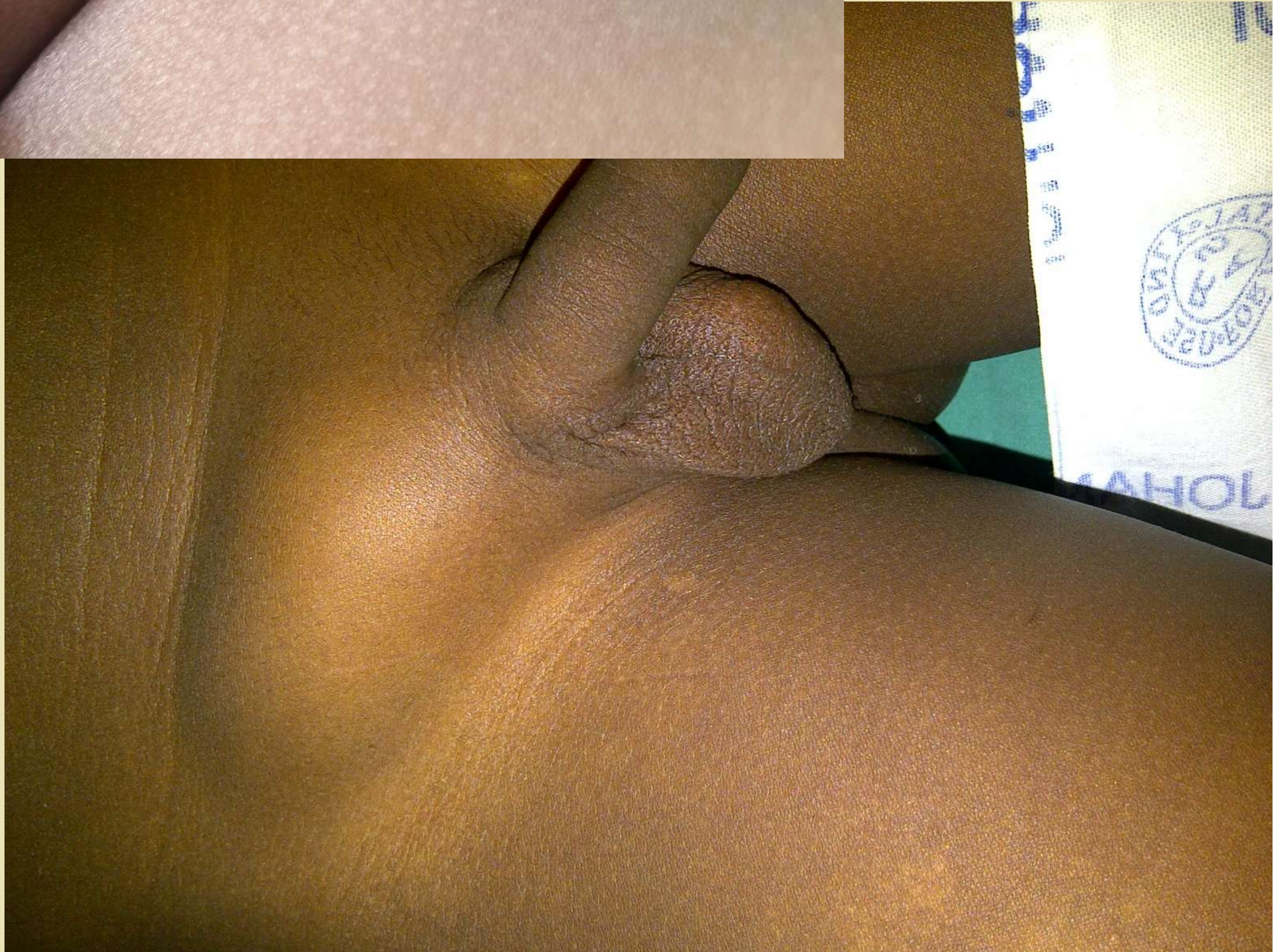

9 0:12


Cryptorchidism

- Wait up to six **months** of age
- Will not descend beyond that
- No need for ultrasound





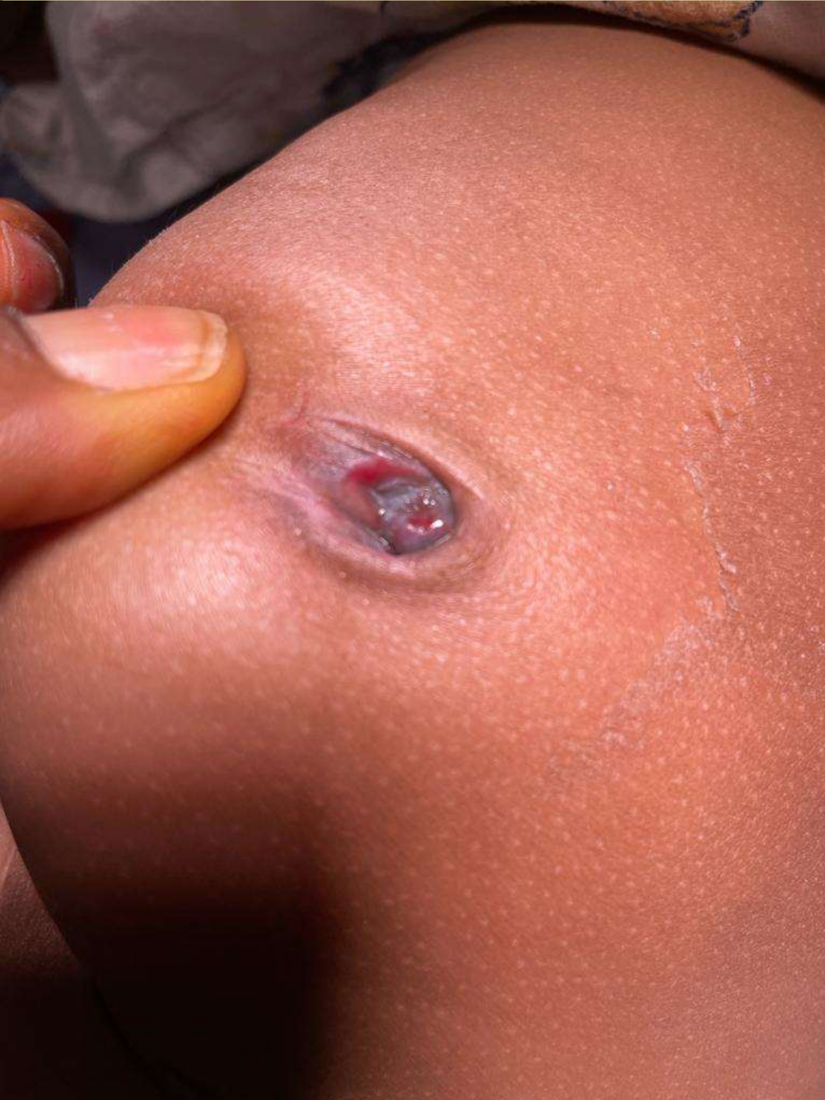
Umbilical

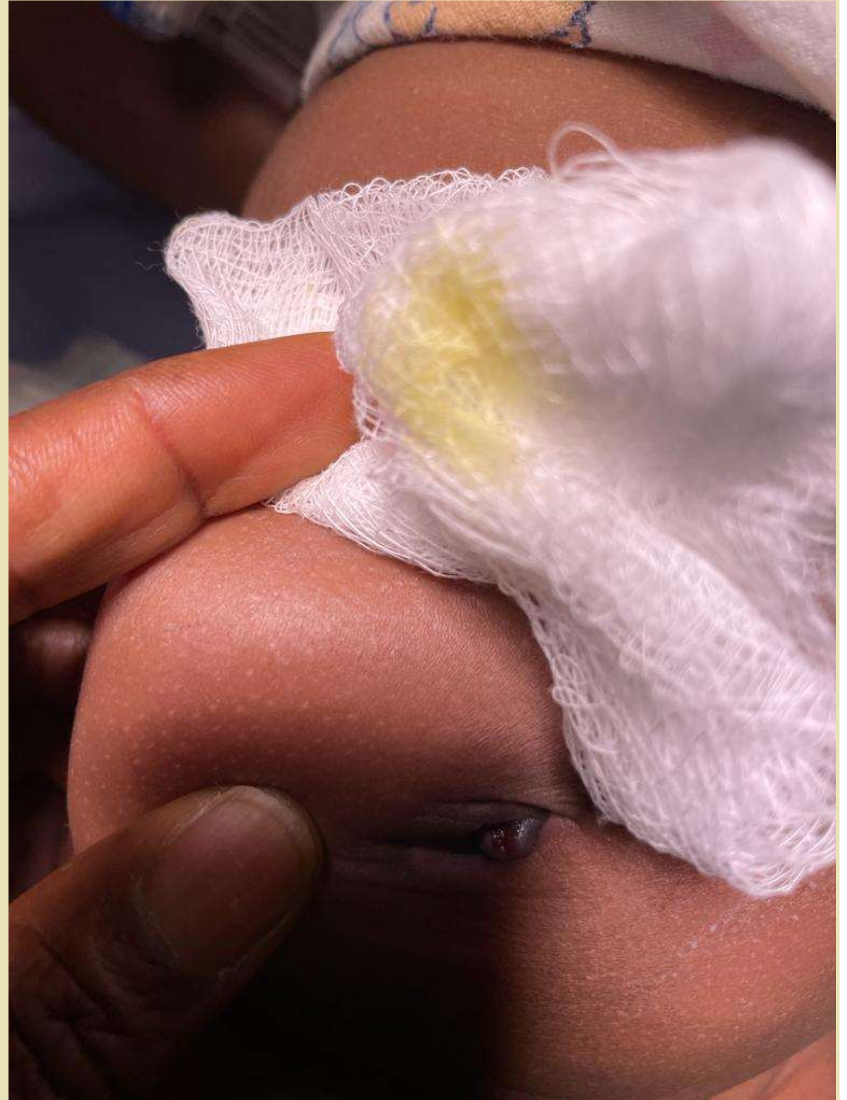
- Hernias
- Granulomas
- OMD/Urachal

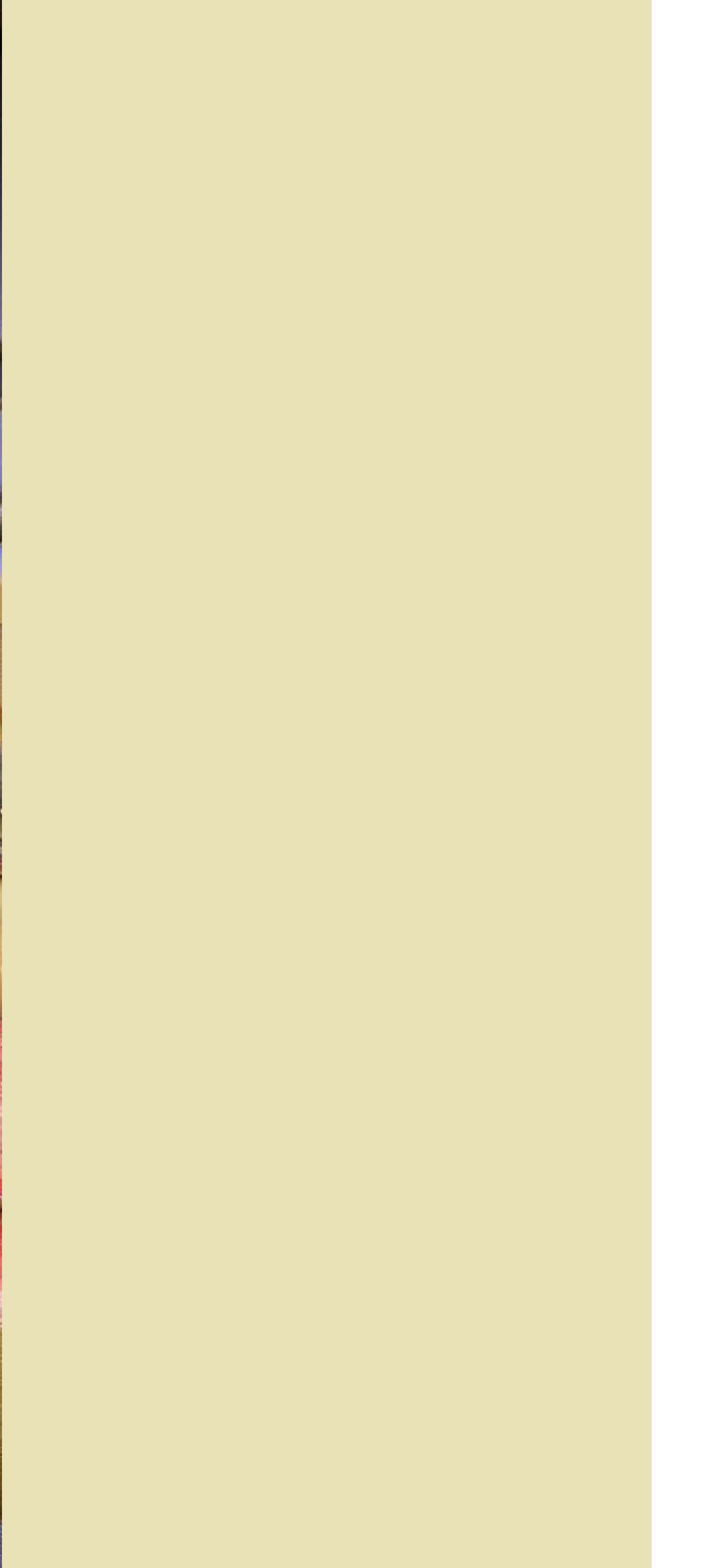
- A 5mo old thriving male infant
- Constant umbilical wetness since umbilical cord fell off at 14 days old
- The fluid/discharge has a yellow tinge, exacerbates intermittently
- Local skin irritation
- No associated symptoms

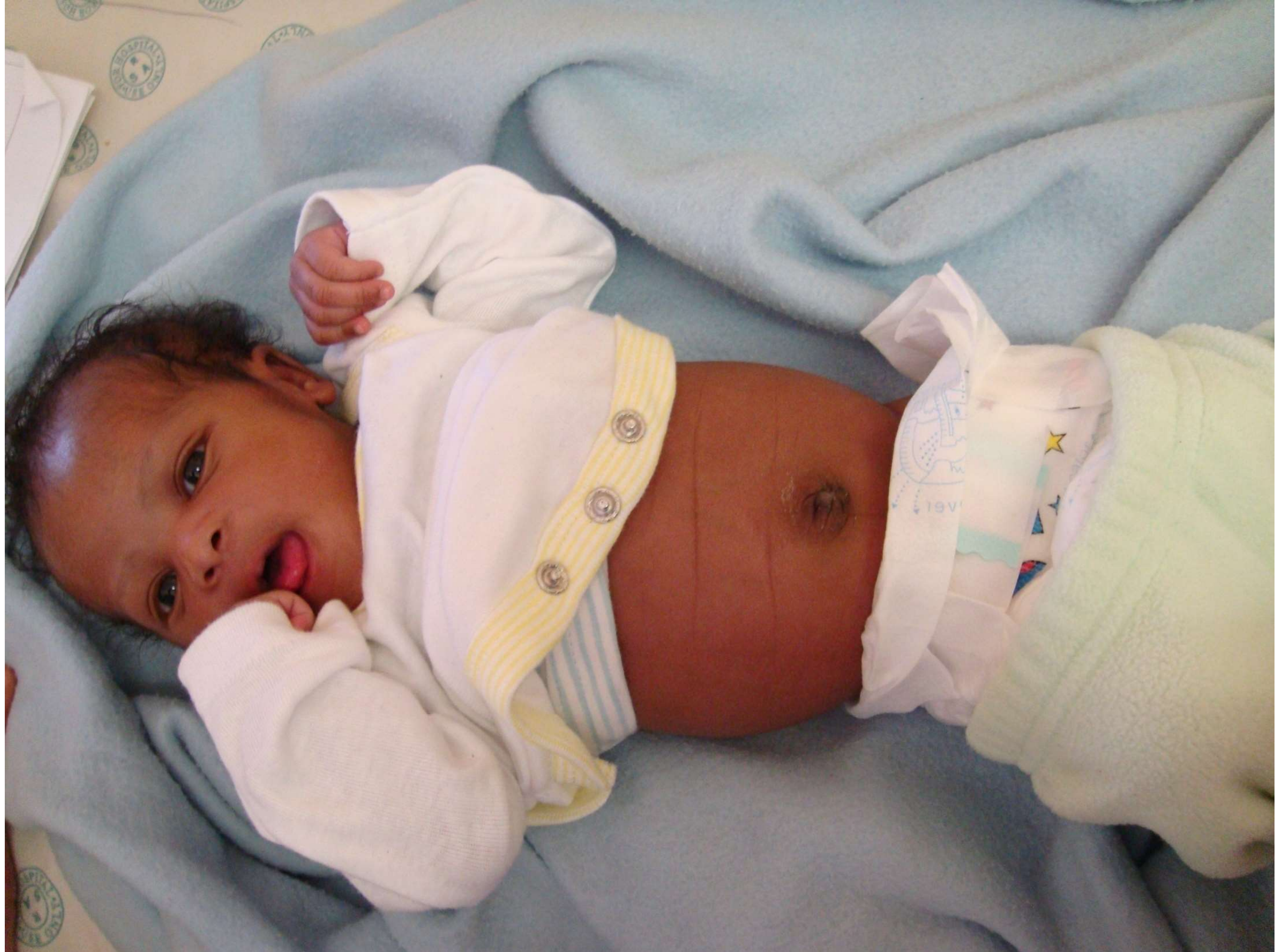
- ?should I be worried

?Differential Diagnosis?







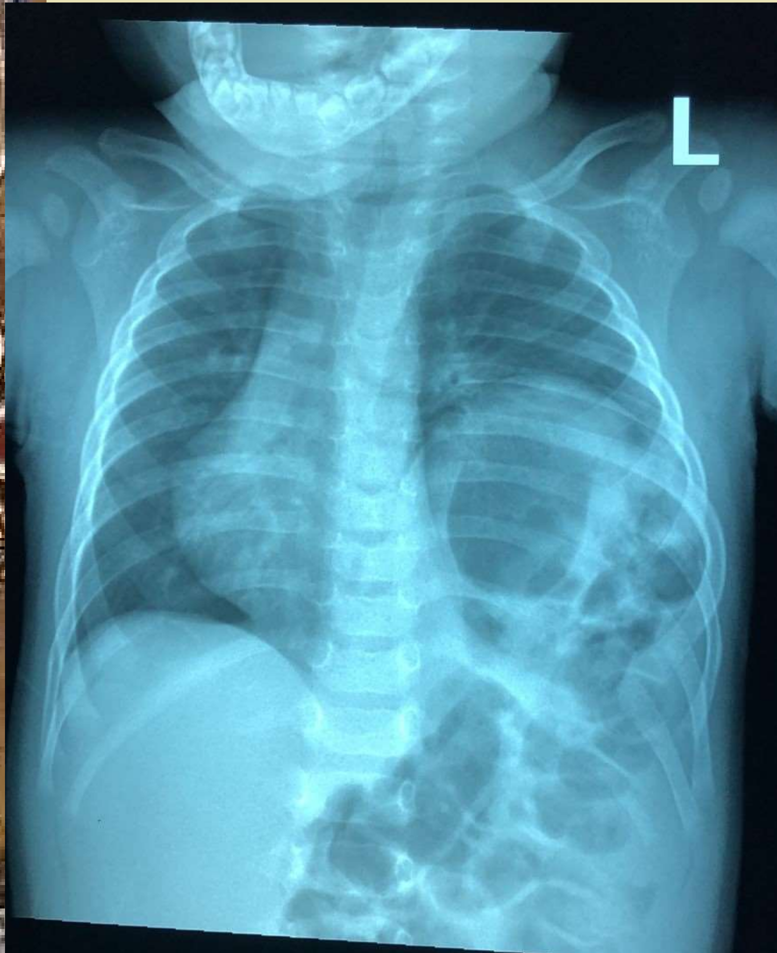


Umbilical Hernia

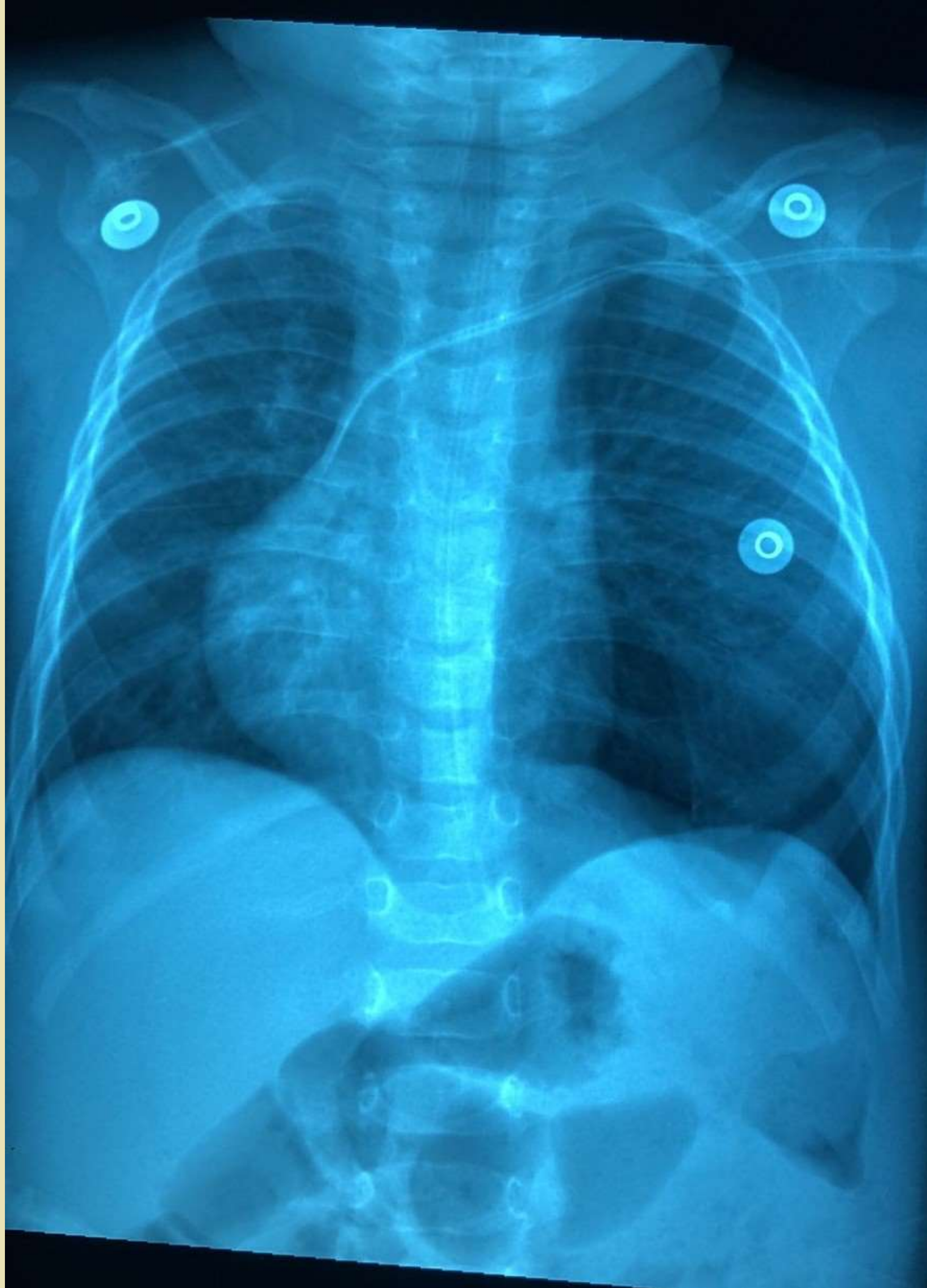
Indications for repair

- Symptomatic
- Very large
- Cosmesis

- First consult 11/2020
- 4mo old
- Normal birth history
- Multiple admissions for respiratory symptoms
- Normal bloods
- Recovers easily

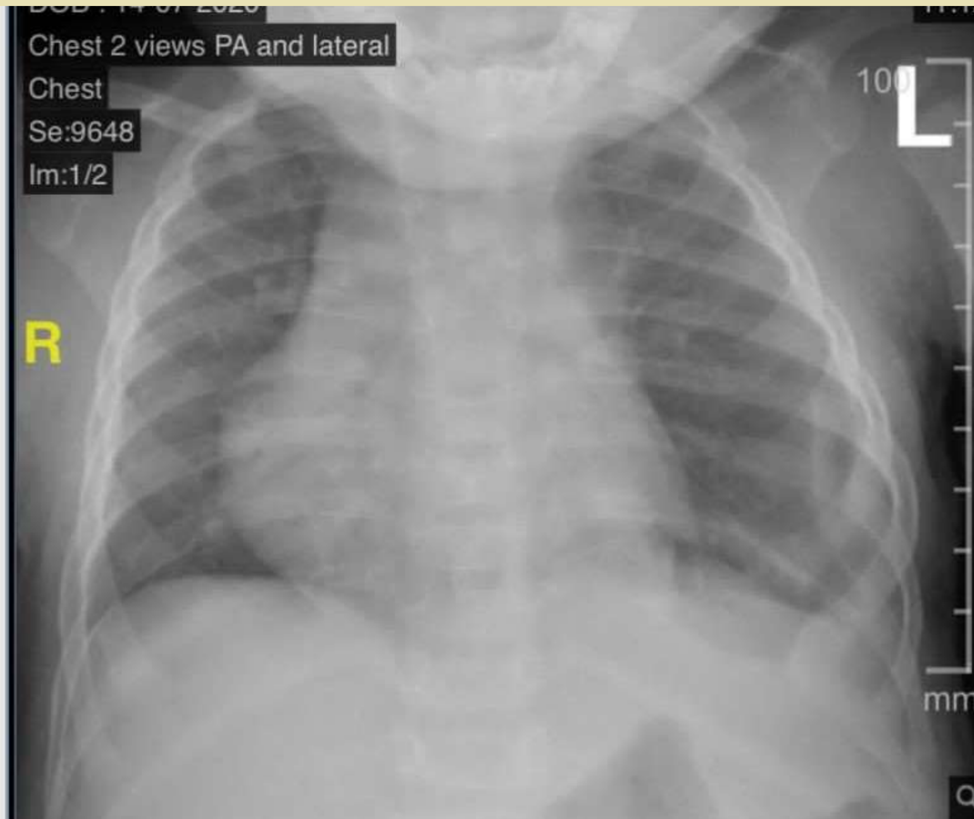


- First consult 11/2020
- 4mo old
- Normal birth history
- Multiple admissions for respiratory symptoms
- Normal bloods
- Recovers easily
- CXR
- Do you think this is the cause?



- Yes it is the cause
- Lets eliminate and see

THE CLINIC 1



I thank God for you,Boka got flue twice already after the op and it ddnt end us up in hospital 🙏🏾what u dd with him is amazing... Thank you 07:40

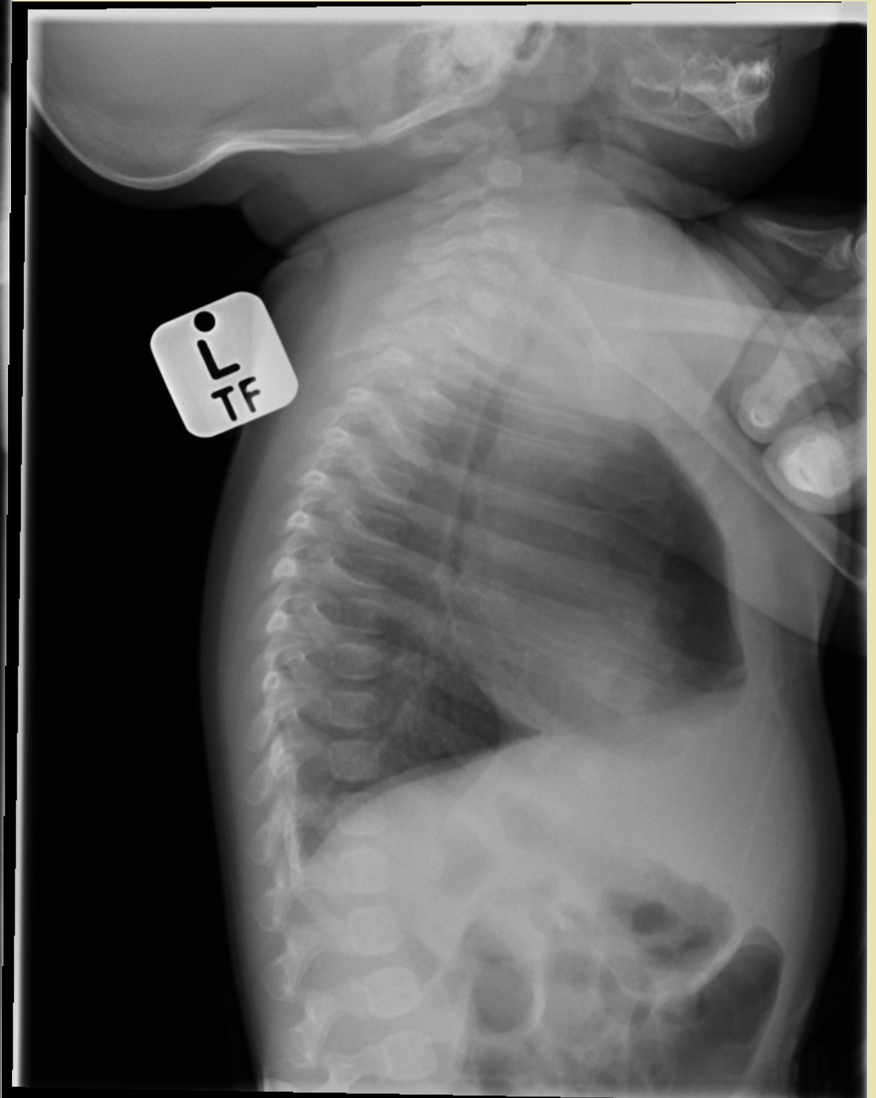
Thank you for your kind words. It is assuring to hear we make a difference. Keep well and keep safe. 08:02

INCIDENTALS

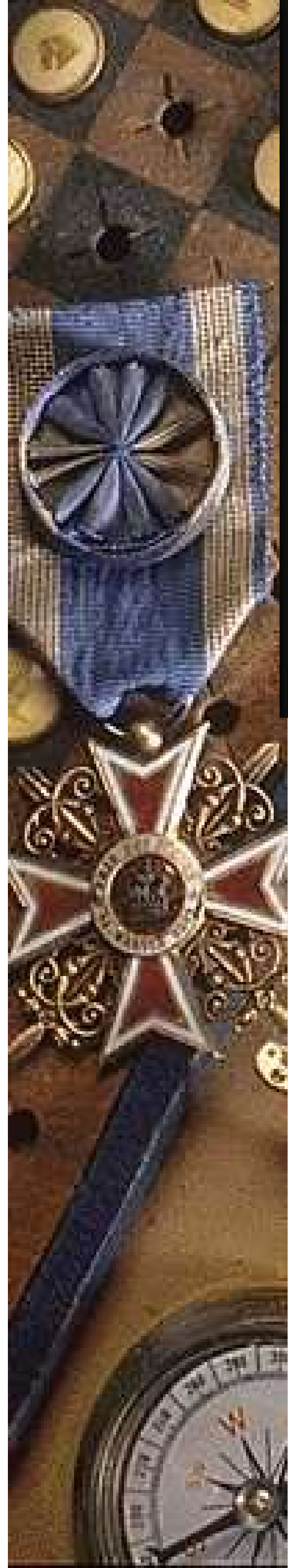
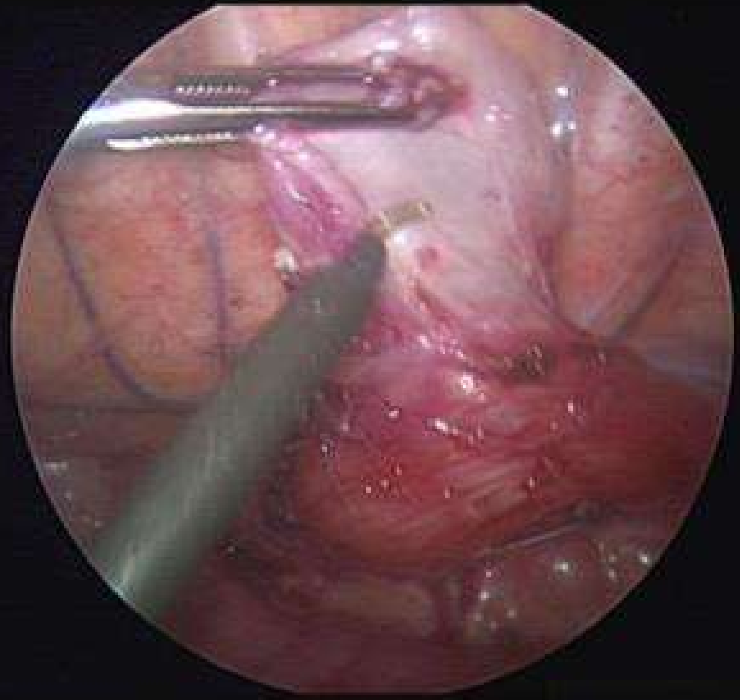
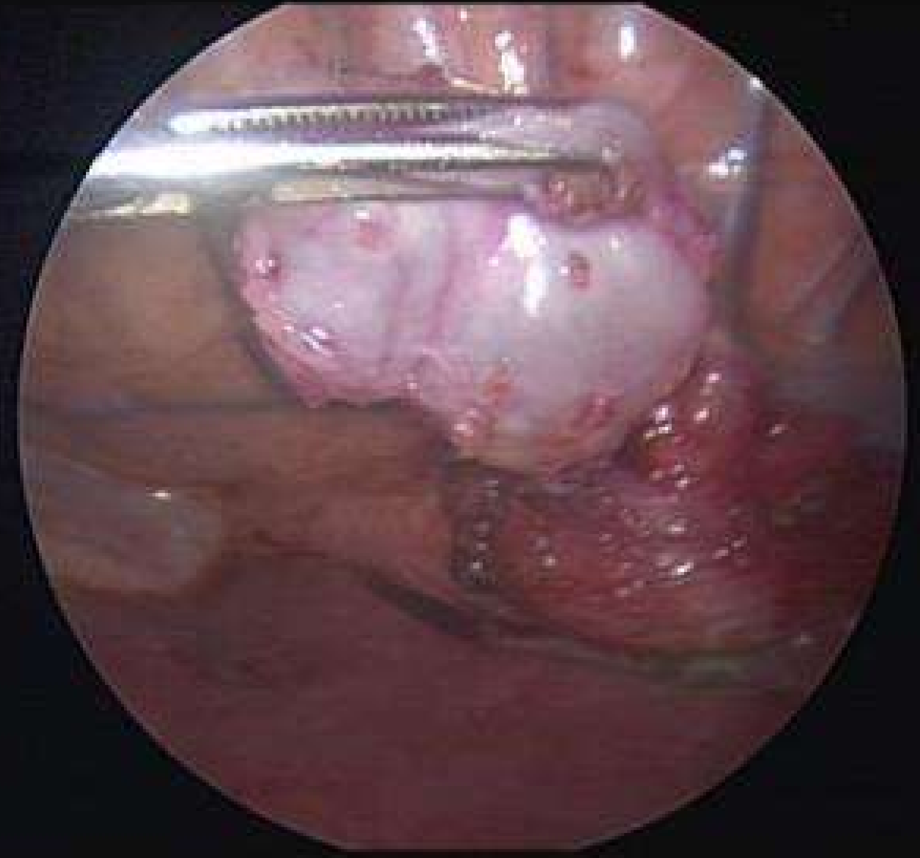
- 8 week old infant presents to the hospital on the third evaluation for intermittent respiratory symptoms and presumed bronchiolitis, previously treated with conservative management by the pediatrician with normal blood tests. The CXR is performed on the third visit

INCIDENTALS

SUPINE



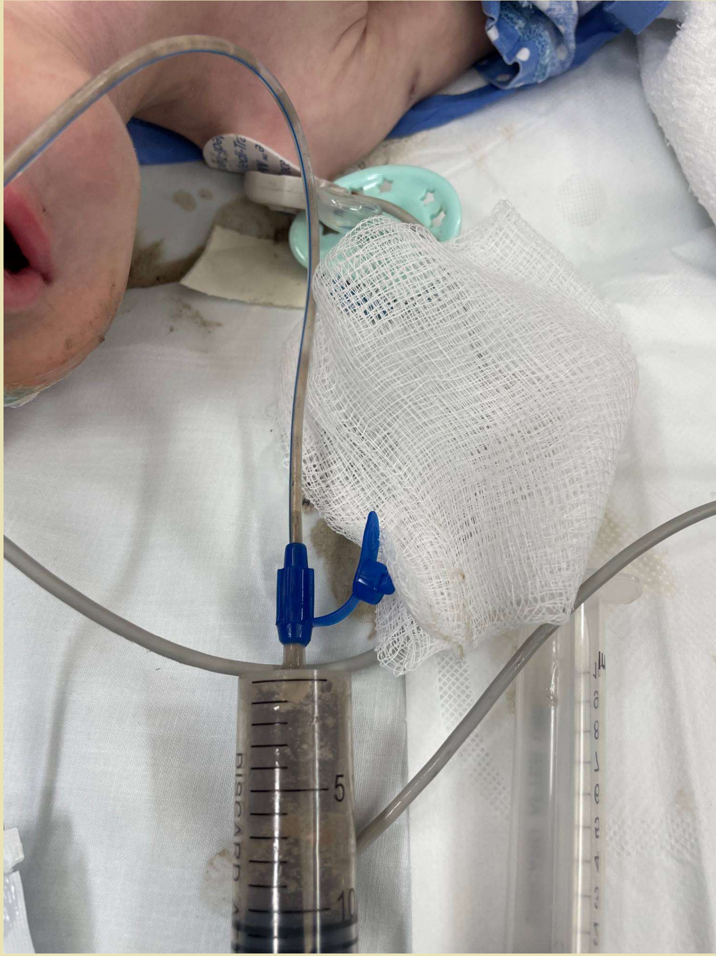
- **6 mo old patient is admitted to pediatrics for suspected viral bronchiolitis**
- **Hx: fever x 3 days, with cough and rhinorrhea and progressive shortness of breath. Multiple family members have also had fever and cough. On examination in the ER, the patient is tachypneic with use of accessory muscles and O2 saturations of 88% on room air. On physical examination, there are bilateral expiratory wheezes. The patient is treated with bronchodilators and oxygen and improves. As part of the workup, the pediatricians order a CXR**

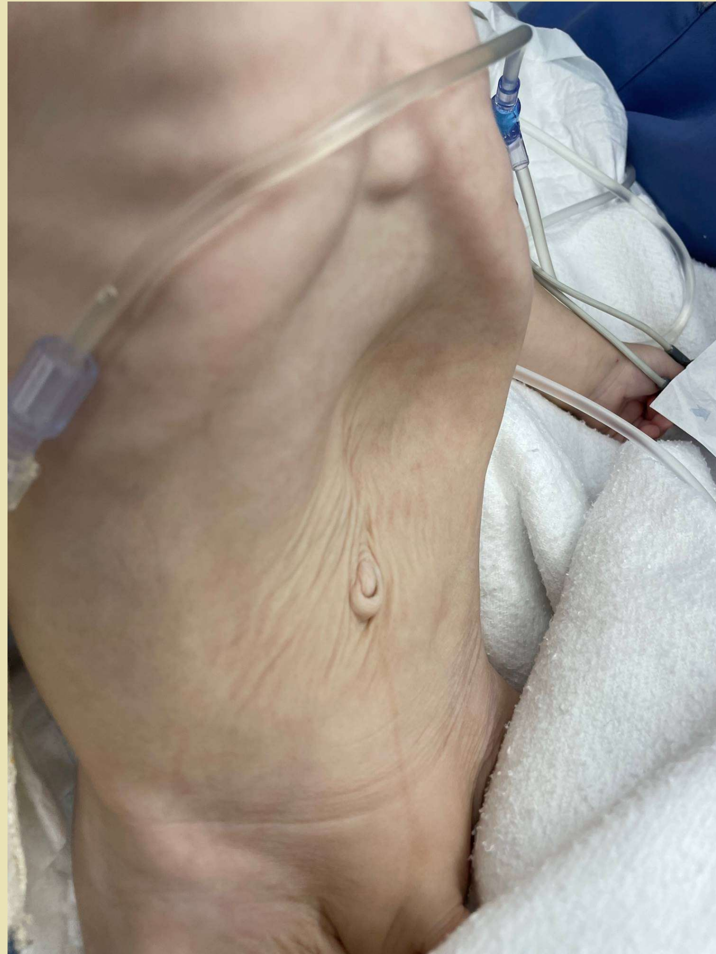
- Common things are common, lets know them well (run of the mill)
- One cannot prepare for contingency, individualised to the case
- Lessons learnt from every patient

- DOB 28/11/2021
- DOC 30/03/2022
- Bwt 3.1kg Cwt 4.2
- “Known” reflux

- DOB 28/11/2021
- DOC 30/03/2022
- DOS 31/03/2022
- Bwt 3.1kg Cwt 4.2
- “Known” reflux
- **Diagnosis Pyloric Stenosis**

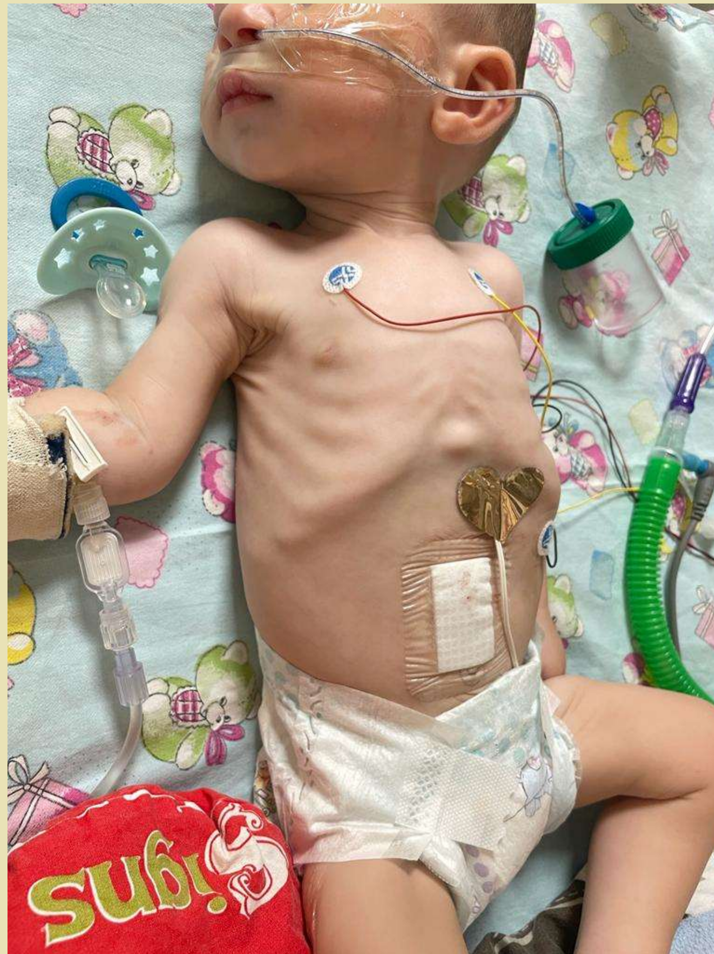


THE CLINIC 2



- ***Emaciated & dehydrated: severity depends on duration of symptoms***
- ***Diff diagnosis {GORD/Vomit} awareness***
- ***Imaging***
- ***Metabolic panel***

POSTOP



- Empty NGT
- May vomit but….
- Graduated feeds vs full/all out

OPD FOLLOW UP

THE CLINIC

- ?
- DOB 23/02/2022
- DOC 20/05/2022
- DOS 23/05/2022
- Bwt 3.795kg
- Cwt 6kg

- FT healthy M infant
- Now 11weeks
- Sy since 2wks old
- On Rx for reflux
- Random episodes

-vomiting, colic, screaming, woken up, can last hours. . .

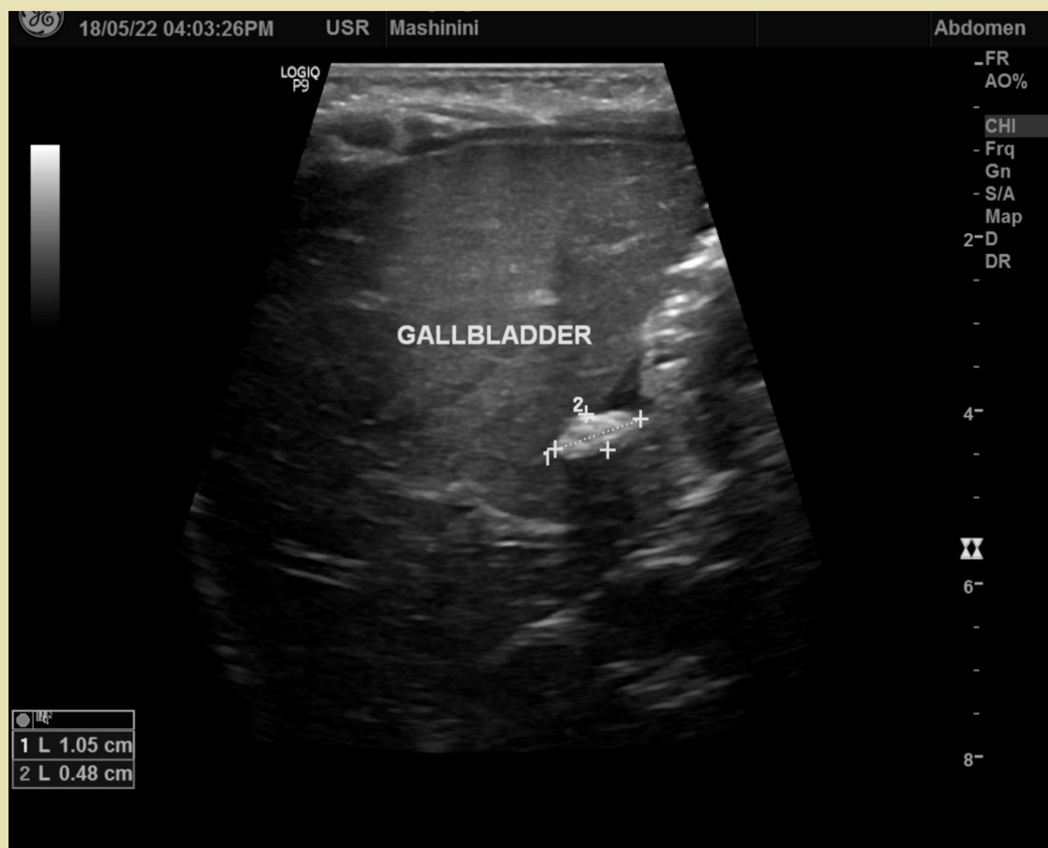
THE CLINIC

- Rushed to doctor during an episode

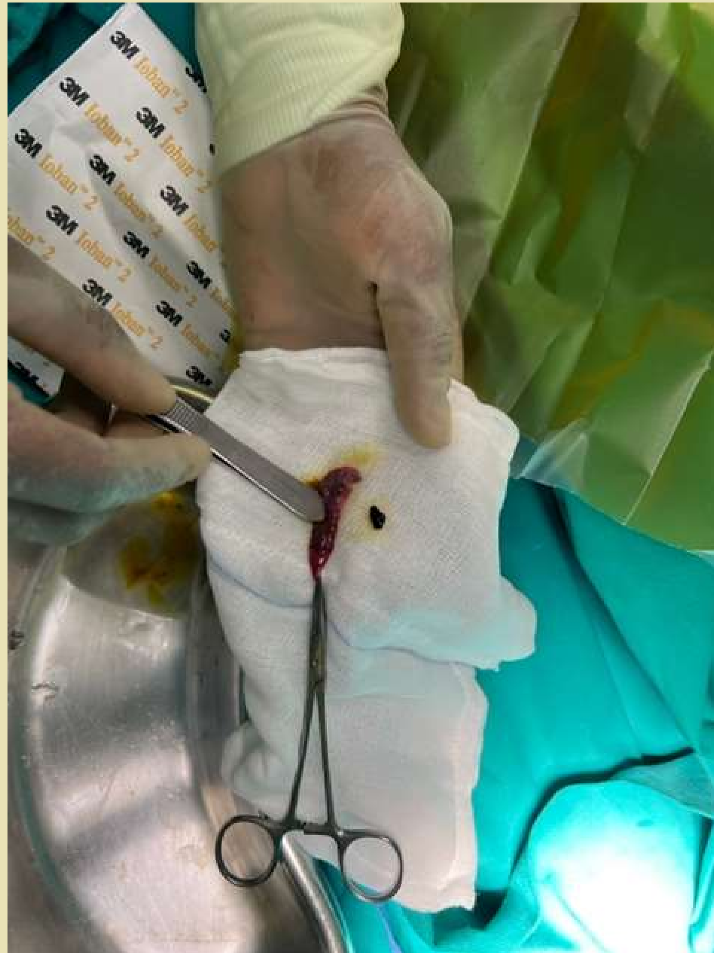
- All imaging
- Bloods

THE CLINIC

- All imaging
- Bloods (CRP 48)
- ABDO ULRASOUND



THE CLINIC



TAKE HOME POINTS

- Listen and Acknowledge: people don’t leave “the streets” for nothing
- If it were you/your child
- Be “willing to change my mind even once it is made up”
- Be “open to revising my decision with compelling reasons”
- The benefits of repair far outweigh the pain/risk of a scar

RECOMMENDATION

- Make ultrasound a routine examination of all abdominal symptoms in children
- A low/er threshold for plain X-rays of the abdomen and chest based on symptoms, even when labs are normal
- Early consideration of upper and/or lower GIT contrast studies

Pearls

- There is no template for curious, creative, authentic and courageous professional response

What if this is a manifestation of less common diease?