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Jejunal Atresia in a Neonate due to Intrauterine Intussusception

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Received: August 23, 2010; Initial review: August 31, 2010; Accepted: December 1, 2010.

We report a female neonate, who presented with abdominal distension and failure to pass meconium. Antenatal ultrasound at 32 weeks gestation and postnatal ultrasound on day1 suggested intestinal obstruction. During laparatomy, atresia of distal jejunum was found. The lumen of the distal segment contained an intussusceptum. Resection of the blind ends was done and end-to-end anastomosis was performed.

Key words: *Intrauterine, Intusussceptum, Jejunal atresia, Newborn*.

Jejunal atresia is generally considered to result from intrauterine vascular disruptions in a segment of the developed intestine [1]. Volvulus, herniation and constriction have been implicated in causation of jejunal atresia [1]. Intrauterine intussusception is a rare cause of jejunal atresia [2].

CASE REPORT

A 20 year old primigravida underwent a routine ultrasound scan at 28 weeks gestation. The scan showed dilated loops of intestine suggestive of intestinal obstruction. A follow up scan at 32 weeks gestation confirmed the findings. At term, a baby girl weighing 2.3 kg was delivered. Abdominal distension was present at birth and gastric aspirate was bile stained. Postnatal ultrasound and X-ray abdomen showed dilated fluid filled bowel loops suggestive of small intestinal obstruction.

Exploratory laparatomy revealed a proximal jejunal atresia 6 cm segment along with curved sausage like loop of intestine 2.5 cm in length i.e., intussusception of the jejunum 25 to 30 cm distal to the duodeno-jejunal junction (Type 1 atresia). The intussusceptum and atretic segment were resected and an end-to-end anastomosis was done. The patient showed good improvement after surgery and was started on gavage feeding on day 5 which was tolerated well and postoperative period was uneventful.

Gross examination of the respected specimen did not reveal any gangrene. Microscopic examination confirmed intussusception. The proximal atretic jejunum had a blind end.

DISCUSSION

Intussusception is rare in the neonatal period. Of about 6000 published cases in the pediatric population, only 28 occurred in the neonatal period [3]. The commonest site was the ileum. The jejunum is an uncommon location. The cause of the intussusception is unknown in majority of the cases. A case of ileal atresia consequent to intrauterine intususception has been reported before in Indian literature [4]. Intrauterine intussusceptions causing jejunal atresia is further rare with only few cases described in the literature [2, 5].

It has been suspected that intestinal atresia may be secondary to prolonged bowel ischemia *in utero* [6], thus a

careful examination of distal blind end is important in making the diagnosis.

Contributors: SD and RB collected patients' records, drafted the manuscript and performed the review of the literature. AN was involved in patient management and reviewed the manuscript. All authors approved the final manuscript.
Funding: None; *Competing interests*: None stated.

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Sporadic Hemiplegic Migraine

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Received: November 1, 2010;
Initial review: November 17, 2010;
Accepted: December 6, 2010

We report a 4-year old boy with probable sporadic hemiplegic migraine. The present case did not fulfill the International Classification of Headache Disorders diagnostic criteria for the disease completely, as it is unclear whether the child had any headache or not. The differential diagnoses are discussed. The case is reported for its rarity and to increase awareness.

Key words : Child, Headache, India, Sporadic hemiplegia migraine.

The phenotype of Sporadic hemiplegic migraine (SHM) attacks may include fever, lethargy, dysphasias, confusion, hemiparesis, hemisensory symptoms, hemianopia and scintillating scotoma. The symptomatology may resemble a stroke. Diagnosis of SHM in most cases is essentially one of exclusion as there is no diagnostic marker, genetic testing is not widely available, and not all genes associated with SHM are yet known [1]. Differential diagnoses include stroke, Todd's palsy, the syndrome of headache, transient neurologic deficit and CSF lymphocytosis (HaNDL), mitochontrial encephalopathy with lactic acidosis and stroke-like episode (MELAS), alternating hemiplegia in childhood, Takayasu disease, and sickle cell anemia [3-4]. Only two reports have previously been published from India [5,6].

CASE REPORT

A four-year old child presented with a transient weakness of the right half of face lasting for 10 minutes. There had been no fever, seizure, headache, visual phenomenon or alteration of sensorium either preceding or during this spell. Speech was normal. Forty eight hours later, he lost his motor speech (comprehension intact) without any hemiparesis and recovered fully in 15 minutes. On the same evening, he again lost his speech, with right sided weakness and facial deviation to the left. This episode was also unassociated with any headache or seizures. He was admitted at a nearby hospital where he recovered in about 3 days time. A CT scan of brain (plain) and a CSF study were normal. He had no family history of vascular disease but his mother suffered from migraine without aura.

When seen about a week later, the child was well and had normal blood pressure and had no neurologic signs or symptoms. All his peripheral pulses were normal and equal. The child was born of non-consanguineous parents and had a normal birth history and motor development. Speech was delayed, and at 4 years, he could only speak monosyllables, though his hearing was normal and comprehension for verbal speech was intact. Routine hematological and biochemical investigations were