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Infected Urachal Cyst - An Uncommon Cause for Incessant Cry in Newborns

A 33 day old baby presented with episodes of incessant cry of 13 days duration, along with drawing up of knees to chest while micturating; intermittent episodes of vomiting, decreased feeding and mild abdominal distension, but no constipation. Two days before presenting to us the mother noticed a swelling in the umbilicus, with increasing periumbilical redness, which ruptured draining pus and blood via the umbilicus, following which the incessant cry subsided. On examination, there was periumbilical redness, umbilical discharge of pus and blood, local rise of temperature and periumbilical induration per abdomen, but no other signs. Ultrasound of abdomen revealed infected urachal cyst. We managed the child conservatively with intravenous antibiotics. On the 3rd post admission day, he developed incessant cry again, along with bilious vomiting, constipation, abdominal distension and decreased bowel sounds (but no fever/ guarding/ rigidity). X-ray showed multiple fluid levels consistent with paralytic ileus/subacute intestinal obstruction. Oral feeds were stopped and IV fluids were administered along with gastric decompression. Laparotomy was planned in the event of non-improvement. However, the child improved in 24 hours, feeds were restarted after 48 hours and the baby was discharged after 1 week, to undergo complete excision at a later date.

In neonates, patent urachus presenting as umbilical discharge is usually seen rather than infected urachal cysts, which have a higher age of presentation [1]. Complications like intestinal obstruction are even rarer [2]. An urachal cyst usually presents when infected as lower abdominal pain, fever, voiding symptoms, a

palpable mass and evidence of urinary infection. If left untreated it may drain into the bladder or through umbilicus. The urachus lies in an extraperitoneal fascial plane, hence an urachal remnant is unlikely to cause an intra-abdominal pathology, particularly intestinal obstruction. However this is seen in neglected infections [2,3]. Ultrasound can be diagnostic in 80 to as much as >90% of cases, where diagnosis is doubtful, a CT scan/MRI is diagnostic [1,4]. Management is controversial with one group advocating a 2 stage procedure - incision and drainage followed by delayed resection [4] and another group arguing that the former was developed in the pre-antibiotic era; and that the use of appropriate antibiotics followed by complete excision as a primary procedure is both possible and safe [1, 5].

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