A Bizzare Case of Battered Child Syndrome

The battered child syndrome or 'child abuse' may be manifested in many ways, including physical and mental injury, nutritional and hygienic neglect, delayed treatment of illnesses, sexual abuse of maltreatment of other forms. We report a rather bizzare form of child abuse, the father being the perpetrator.

A $2^{1/2}$-year-old boy was brought to Christian Medical College. Ludiana for management of a tight mid-esophageal stricture resulting from accidential caustic ingestion. A gastrostomy was performed and he was started on a regimen of retrograde esophageal dilatation using Tucker dialators. A no. 1 nylon thread passed via the nose and pulled out from the gastrostomy site was left as a retrieval line. The two ends of the thread were rolled over spools and taped onto the cheek and abdominal wall respectively. After the third esophageal dilatation, the child was brought twice to us within a period of one week with loss of the retrieval line. The first time Ravitch's technique of introducing the orogastric string was used(l). The child was admitted and a spool of nylon thread was suspended above the child's head and the end of the thread was passed into the baby's mouth. As the baby chewed and swallowed, the thread found it's way through the stricture into the stomach from where it could be retrieved with a clamp under general anesthesia, the second time, we could pass a nylon thread attached to an infant feeding tube no. 10 across the stricture rather easily. The same could be fished out through the gastrostomy without any anesthesia.

The child had never been accompanied by his parents and the aunt who brought him to the hospital was very reluctant to give an accurate account of the facts. When repeatedly questioned, she confessed that the retrieval line had been pulled out by the father. On further probing she narrated that it was not an accidental ingestion, but the father had knowingly made the child drink the caustic. He was abusing the child as part of his tactics to pressurize his wife to agree to 'divorce by mutual consent', for which she was unwilling.

It is on record that orogastric string used as retrieval lines for retrograde dilatation have been inviting harrassment by peer and siblings(2), but a father being a perpetrator has never been reported. An ingenious method of concealing such a string has been described(2). When confronted with such a situation, a method described by Mercer *et al.*(3) to recover the lost retrieval line under direct vision is best resorted. Other methods of blind insertion either using an endotracheal tube or a Teflon coated arterial wire through the gastrostomy and up into the esophagus have also been described (4,5).

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Congenital Duodenal Diaphragms in the Third Part of Duodenum

The incidence of duodenal atresia is 1 in 10,000 live births(l). Most cases show atresia in the second part of the duodenum. Duodenal diaphragms in the third part of the duodenum are rare(3,4). We report a patient with a duodenal diaphragm in the third part of the duodenum, who presented for the first time at 2 yr of age.

A 2-year-old girl was admitted with the complaints of distension of abdomen and intractable vomiting for 3 days. There was intermittent distension of abdomen and intractable vomiting since 1 week of age. The vomitus was offensive in smell, contained food materials and was bile stained. The episodes lasted for 3 to 4 days and were relieved with medicines and oral fluids, only to recur after 2-3 weeks. She also suffered from constipation. She was admitted in two different hospitals at the age of 2 and 18 months with severe dehydration following vomiting. The child was solely breastfed upto 3 months. Then cow's milk was added to her diet. From one year of age she used to take mashed rice, khichri and banana. The birth and developmental history was normal.

The child weighed *7.5* kg and the length was *73* cm; both were below the 5th percentile. On examination she was markedly dehydrated. The epigastric region showed visible peristalsis. Investigations showed hemoglobin 11.5 g/dl, and total count 8000/cu mm. Straight X-ray of abdomen in erect posture revealed double bubble appearance but there was gas in the distal intestine. The child received replacement fluids and electrolytes. The abdomen was explored one week after admission through a transverse incision. The stomach and duodenum were found to be distended in continuity up to duodeno-jejunal (D-J) junction. The D-J flexure was mobilised. Rest of the gut was found to be absolutely normal. An enterotomy was performed along the long axis of the gut at the level of D-J junction using an 1" incision. A web was found obliterating almost whole of the lumen with only a small pinhole opening in the centre. The web was excised circumferentially and