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Anterior Cutaneous Nerve Entrapment Syndrome (ACNES): The forgotten diagnosis

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Anterior cutaneous nerve entrapment syndrome (ACNES) is an often overlooked cause of (chronic) abdominal pain. This was first recognized by Carnett and Bates in his seminal article in 1926. However, nowadays, many physicians are still unaware of this diagnosis. The literature on prevalence of ACNES in the pediatric population is very scarce. Only recently, ACNES has been described in children. Abdominal pain can be classified as visceral pain caused by intra-abdominal organs or parietal pain originating in the abdominal wall. ACNES causes' abdominal wall pain and it is believed that in ACNES, superficial branches of the intercostal thoracic nerves become entrapped between the abdominal muscles and cause pain on this specific location of entrapment. In its presentation, ACNES may therefore mimic an intra-abdominal source of the pain like appendicitis. Carnett first described a test in which the specific point of maximal pain is identified by the investigator after placing patient in supine position. The patient is then asked to raise the head and shoulders. When doing the test right, the abdominal muscles should be contracted. The pain will increase and is pinpointed with a fingertip. Carnett's sign is then positive and ACNES becomes more probable. Pain of visceral origin usually diminishes during this test. Immediate relief of pain after administering a local dose of anaesthetic in the rectus sheath at the location of the point of maximal tenderness strongly supports the diagnosis of ACNES which is also first line in treatment for ACNES

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Hospital neonatal mortality and morbidity in Vietnam

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Background: Neonatal deaths constitute the majority of child mortality in Vietnam, but studies are scare. In a prospective cohort study, we investigated deaths and discharge diagnostics among hospitalized neonates.

Methods: During a 12 months period, neonates admitted to a province general hospital and a tertiary pediatric hospital, were studied. Potential risk factors of death covering socio-demographic, pregnancy history, previous neonatal period and admission status were registered at entry. The neonates were followed until discharge, death or withdrawing of life support or to 29 days of age if still admitted. The main outcome was neonatal dead.

Results: Among admitted neonates of 2 hospitals, the discharge diagnoses were infection (91.8%, 76.8%), prematurity (20.0%, 15.3%), congenital malformations (4.7%, 16.4%) and asphyxia (4.4%, 4.3%). The hospital neonatal mortalities were 4.6% and 5%. In a multivariate analysis, associated risk factors of death were very / extremely low birth weight, no cry at birth and poor admission condition.

Conclusion: Prematurity and asphyxia were diagnosed less frequently and infection more frequently than expected. The neonatal mortality was about 5%. No socio-demographic factors were associated with death.

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