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Helal technique for simplified single incision laparoscopic pediatric inguinal hernia repair

Ahmed Abd Elgaffar Helal
MGM Medical College, India

Background: The desire to reduce number of incisions and postoperative pain while achieving better cosmoses has recently led to the introduction of single incision laparoscopic hernia repair (SILHR). Intracorporeal knotting, remain a major challenging tasks for pediatric surgeons during SILHR. We introduce a simplified technique for pediatric SILHR with intracorporeal knotting.

Patients & Methods: This prospective study was conducted at Al-Azhar University Hospitals, between Feb 2014 and Aug 2016. One hundred children with hernia defects were subjected to SILHR. Extraperitoneal saline was injected around internal inguinal ring [IIR] in males. The opened IIR was closed by percutaneous insertion of purse string suture using epidural needle gauge-18 with intracorporeal knotting. The main outcome measurements include: Operative time, feasibility of the procedure, complications and cosmesis.

Results: Ages ranged between 6 months and 7 years (mean[2]±24.2 years). They were 81 males and 19 females. Thirty four patients presented with right sided inguinal hernia, 46 patients with left sided hernia, and 20 patients with bilateral hernia. The mean operative time was 8±2.2 minutes for unilateral hernia repair and 16±4.3 for bilateral cases. On follow-up, there was only 1 case of recurrence and 1 cases of hydrocele and the scar is nearly invisible.

Conclusion: Our technique is very simple to achieve secure closure of IIR and reduce operative time with excellent cosmetic results. It avoids the drawbacks of extracorporeal knotting.

helalhmada@yahoo.com

Etiologies and early diagnosis of short stature and growth failure in children and adolescents

Alan D Rogol
University of Virginia, USA

Accurate measurement of height and weight using standardized techniques is a fundamental component of pediatric medical visits. Calculation of height velocity over time enables comparison with standardized growth charts to identify potential deviations from normal. Growth deviations may be expressed as SD from the normal population mean for children of comparable age and sex; children with heights >2 SD below the mean are generally classified as short stature. In a child with suspected impaired growth, a detailed evaluation should be conducted to identify the cause. Such an evaluation may include a combination of personal, family, and social history; physical examination; general and perhaps specialized laboratory evaluations; radiologic examinations; genetic testing; and consultation with a pediatric subspecialist, such as a pediatric endocrinologist. Variants of normal growth include familial short stature, constitutional delay of growth and puberty, and small for gestational age with catch-up growth. Pathological causes of abnormal growth include many systemic diseases and their treatments, growth hormone deficiency, and a series of genetic syndromes, including Noonan syndrome and Turner syndrome. Children with short stature in whom no specific cause is identified may be diagnosed with idiopathic short stature. Early identification of abnormal growth patterns and prompt referral to specialist care offer children with growth failure and/or short stature the greatest chance for appropriate diagnosis, treatment, and improved clinical outcomes.

adrogol@comcast.net