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Bilateral Cryptorchidism

The undescended testis is the most frequent disorder of male sexual differentiation affecting 0.8% of boys by age one year. The etiology is varied but many cases represent disturbances of the hypothalamic-pituitary-gonadal axis and may represent a forme fruste of hypogonadotropic hypogonadism. Bilateral cryptorchidism occurs in 10-30% of cases. Management consists of hormonal therapy a/o surgical orchiopexy. Human Chorionic Gonadotropin (HCG) is superior to Gonadotropin Releasing Hormone (GnRH) and placebo in the treatment of bilateral cases, with success rates of 23%. Regression analysis showed treatment is more successful the younger the child; after six months of age medical treatment with LHRH and HCG has produced descent in half managed cases. A recent study in young male rat revealed that the fertility defect is partially prevented by early orchiopexy and adjunctive hormonal therapy is probable of little additional benefit. Infertility is common in patients with history of bilateral cryptorchidism even after successful prepubertal orchiopexies, and azoospermia is present in 18% of bilateral cases pexed as children. Although the undescended testis experience a substantial increase of developing later malignancy, the absolute risk is so small that does not appear to justify special surveillance after surgery. Laparoscopy for the impalpable and bilateral undescended testis is of value to diagnosed testicular absence, identify intra-abdominal testis, and transect vessels for later Stephen-Fowler approach.

Achalasia

Achalasia in children is an uncommon esophageal motor disorder distinguished by clinical, radiological and manometrics features. Incidence is estimated in 0.1 cases/year per 100,000 population under 14 years of age. Clinical presentation is characterized by progressive dysphagia, regurgitation, weight loss, chest pain and nocturnal cough. Infants exhibit failure to thrive. Diagnosis is established by barium swallow and confirmed by manometry and motility studies. Ba swallow shows' esophageal dilatation, motility alteration and a small caliber (bird-beak) cardio-esophageal junction. Manometry reveals elevated E-G sphincter pressure, non- peristaltic esophageal contraction and

failed relaxation of lower esophageal sphincter upon swallowing. Videoflouroscopy can be of help in the screening of esophageal motors disorders. Esophageal pneumatic balloon dilatation is not an effective method of treatment in children due to the high rate of recurrence of symptoms. Primary therapy is surgical (Heller's modified esophagomyotomy), and results are similar after a transabdominal or thoracic approach. Many authors favor a concomitant antireflux procedures in these patients. Nifedipine can be of help as a short management in preparation for surgery. Long-term result presents' a connection between achalasia and malignant disease of the esophagus.

Christmas Tree Deformity

This anomaly consists of a proximal high jejunal atresia with the blood supply of the distal jejunum and ileum supplied by the ileocolic and marginal vessels. The small intestine distal to the atresia is coiled in a spiral-like fashion around a rudimentary mesentery similar to an apple-peel or Christmas tree. The etiology is a intrauterine vascular accident (block) after the take off of the first branch of the superior mesenteric artery. Most are premature infants with associated malrotation. Management consist of tapering the proximal jejunum and anastomosing it to the distal bowel peel. Malabsorption can be a post-op problem until the blood supply and intestinal length improves. Parenteral nutrition has improved survival rates of this patients.

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