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Parotid Mass

A parotid mass in a child creates great concern and should be managed promptly since a high percentage of cases will harbor a malignant tumor. The more common benign parotid tumor in children includes hemangioma, pleomorphic adenoma and lymphangiomas. Infants with a rapidly enlarging violaceous or soft tumor in the parotid region harbors a hemangioendothelioma. Hemangioendothelioma is the most common parotid gland tumor of childhood. They seldom need excision as spontaneous regression is the norm. An asymptomatic, slow growing solid mass is the most common presentation in older children. Tenderness is associated with an infectious process. Diagnosis includes the use of Doppler ultrasound, CT-Scan, MRI and fine needle aspiration (FNA) biopsy. Salivary gland carcinoma is rare in children. Most common histological type is mucoepidermoid either as a primary neoplasm or secondary malignancy after neck irradiation. Management consists of superficial or total parotidectomy extent which is selected during the surgical procedure depending on deep gland or fascial nerve involvement. The tumor must be widely excised. Recurrence is managed with postoperative irradiation for high or intermediate grade malignancies. Rhabdomyosarcoma arising in the parotid gland area is another locally invasive aggressive tumor that presents early with swelling and symptoms of seventh nerve deficit. This tumor needs surgical excision followed by chemotherapy and irradiation.

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Perineal Hemangioma

Hemangiomas continue to be the most common benign tumor in infants. Perineal hemangiomas involving the scrotum, perianal region and rectum have been sporadically described. Lesions of the anogenital area have a strong predilection for females. The

clinical presentation can start with an undiagnosed non-healing ulcer, a pale macule, erythematous papule, bruise or port-wine stain in the perineal region. Recurrent perianal blood loss can be caused by a rectal hemangioma. Local factors such as abrasion or maceration plays a potentiating role in ulcer development. MRI helps determine the extension of the hemangioma toward the pelvis and surrounding tissues. Though most hemangiomas spontaneously involute over a period of years, those located in the perineal and ano-rectal region are troublesome lesions causing repeated ulcerations and subsequent pain. The subcutaneous perineal hemangioma can be managed conservatively, with systemic steroids or using alpha interferon therapy depending on the symptomatology of the child. Diffuse cavernous hemangioma of the colon, rectum and anus can be managed with initial temporary colostomy followed by modified endorectal pull-through.

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Fetus-in-Fetu

Fetus-in-fetu is a very rare condition in which a malformed parasitic twin is found inside the body of its partner as an abdominal fetiform calcified mass. They are typically located in the retroperitoneum. Symptoms relate to the mass effect and include abdominal distension, feeding difficulty, vomiting and dyspnea. It represents an abortive attempt of identical twinning where one fetus (the parasite) is drawn into the abdominal cavity of the host fetus (the autosite) in early intrauterine life and is attached retroperitoneally, with the blood supply to the former supplied by the host superior mesenteric vessels. There exist much controversy in the literature whether a fetus-in-fetu is a well-formed teratoma (tumor composed of the three germ cell layers) or not. To be coined fetus-in-fetu the mass must demonstrate true organogenesis and an axial skeleton separating them from teratomas, which never undergo organogenesis. Nonvisualization of the vertebral axis on radiography or on CT Scan does not exclude the diagnosis of fetus-in-fetu as it can be seen by the pathologist. Chromosomal analysis of the fetus shows normal chromosomes identical to the host. Management consists of complete surgical resection in as much as malignant recurrence has been reported.

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