AN UNUSUAL CAUSE OF ABDOMINAL PAIN IN CHILDREN

PADMAVATHY.V
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G5 WARD, ICH & HC.
CLINICAL SCENARIO

- 6 yr old male child.
- Referred from Chengalpet medical college.
- c/o poor appetite & loss of weight for 1 yr
- abdominal pain for 1 month
- fever for 2 days prior to admission.
At Chengalpet:

- **Hb**: 10.4gm%
- **TLC**: 16500; P91 L7 E2
- **Platelet count**: 2.1 lakhs
- **TBR**: 0.7 **DBR**: 0.2
- **OT/PT**: 11/14 **SAP**: 97
- **Tot protein**: 7.5
  - **Alb**: 4.1 **Glo**: 3.4
- **Amylase**: 150 IU
- **Widal**: negative
- **CXR**: NAD
- **X Ray Abd**: NAD
- **USG Abd**: Normal study
- **ECG**: Normal study
- **Sugar**: 94
- **Urea**: 26; **Creat**: 0.9
- **Na**: 139; **K**: 3.3; **Hco3**: 23
At ICH

C/C - Abdominal pain

- Intermittent
- Periumbilical
- Typically postprandial, starting at around \( \frac{1}{2} \) hr to 1hr after food.
- Assoc with refusal of feeds
- No vomiting/diarrhea/abd distension/malena/constipation

“PHAGOPHOBIA”
Clinical profile

- **Prev illness**: Known case of Seizure disorder on regular treatment with Tab.Valproate 1-0-1/2 for 2yrs.

- **Family h/o**: 1st born male child out of non-consanguinous marriage.
  
  No family h/o chronic illness

- **Birth history**: Uneventful.

- **Developmental h/o**: Normal milestones.

- **Contact h/o**: No h/o contact with a case of PTB.
On Examination:

- Grade III undernutrition
- Scaphoid abdomen with mild epigastric tenderness, with the child writhing with pain when symptomatic.
- Other systems- NAD
Provisional diagnosis

- Gastritis
- Acute pancreatitis
- Tb abdomen
Investigations

- **Hemogram:**
  - Hb: 9.6
  - TLC: 12800; P57 L43
  - Platelet: 3.4 lakhs
  - PS: Mod hypochromic anemia

- **Urine / Stool:** NAD

- **HIV:** Non reactive

- **RFT/LFT:** WNL

- **Amylase:** 55 IU/ml

- **ESR:** 8/24

- **Mantoux:** negative

- **RGJ:** Negative

- **Parental screening for Tb:** Negative

- **Xray Chest & Abd:** NAD

- **INITIAL USG ABD:**
  - Dilated stomach & duodenum with minimal free fluid in pelvis.
Paediatric surgeons suggested BMFT & Vascular surgeon’s opinion

Vascular surgeons suggested CT angiogram of abdominal aorta with mesenteric vasculature.

Surgical Gastroenterologists advised to treat as Abdominal angina & start Inj. Heparin infusion.
Barium meal follow through - dilated bowel loops with no ischemic changes, with no malrotation.

Hematologist’s opinion -
Serum Homocysteine - Normal
Pro thrombotic work-up after the acute episode settles down.
Heparin infusion
CT Angiogram

- Hepatic & Splenic arteries arising from the Superior mesenteric artery (a normal variant).
- SMA thrombus (distal to the hepatic & splenic arterial origins) with multiple collaterals.
- Large collateral between the hepatic & IMA (Arc of Riolan).
Upper GI endoscopy - Pan erosive gastritis with duodenitis.

ECG - Normal

Cardiac evaluation: Normal study of the heart & great vessels.
Course in the hospital

- Inj. Heparin infusion
- PPI therapy
- Child became asymptomatic nearly 15 days after starting anticoagulants & PPI therapy.
- Better appetite & gain in weight.
- Discharged on Oral anticoagulants, pending prothrombotic work-up.
Working diagnosis

- Gastritis with SMA thrombus

SMA thrombus D/D:

- Mesenteric vasculitis
- Prothrombotic states
- Isolated idiopathic superior mesenteric artery thrombus
On Follow up
STATISTICS
The possibility of Vascular problems should be considered in children with abdominal pain.
Thank you