

plantation, etc. which may actually provide longevity to such babies, so that they do not remain a burden to the parents.

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## Gastric Teratoma

Teratoma of the stomach is exceedingly rare. Since the report of the first case in a 32-year-old male in 1922 only 48 cases have been reported so far(1). It predominantly occurs in males, only two cases have been

reported in females(2,3). Most of the cases presented under one year of age(4), the youngest at the age of 5 hours only(5). The commonest presenting feature is an abdominal mass with progressive abdominal distension. Recently, we saw a 3½ month old baby with gastric teratoma presenting with dyspnea in addition to a huge abdominal lump. The lump was first noticed at 1½ months of age occupying the left upper quadrant of the abdomen. For the last one month it had rapidly increased in size and for the last one week the patient had developed dyspnea. The patient used to vomit occasionally with bile stained gastric content.

The abdomen was grossly distended and the lump was occupying almost the entire abdomen except the right flank with upper margin concealed under the costal arch. The lower margin was rounded and was halfway between the umbilicus and the pubic symphysis. The surface was irregular with soft to firm consistency. It moved with respiration and was dull on percussion. The straight X-ray of the abdomen showed a huge soft tissue mass with areas of calcified densities. An ultrasonographic study showed the mass partly cystic and partly solid, and the kidneys normally situated with normal size and shape. The excretory urogram did not show any abnormality.

On laparotomy, a firm mass, covered with the greater omentum, was found projecting in between the stomach and the transverse colon and was seen arising from the posterior wall of the stomach at its antral region close to the greater curvature. The tumor was excised alongwith 1.5 cm of healthy tissue around the gastric attachment. The stomach was repaired in two layers. The patient had a stormy post-operative period with severe gastroenteritis but he was relieved of dyspnea as it was

due only to the pressure of the mass on the diaphragm. The patient was discharged on the twelfth postoperative day.

The resected specimen measured 18 × 12 × 10 cm and weighed 1.1 kg. The cut surface was greyish white in most of the areas with scattered yellowish regions in between. On histological examination sections showed a matured teratoma containing tissues of skin and its appendages, brain, muscle, cartilage, choroid and respiratory epithelium.

The prognosis of gastric teratoma is very good. Patients died of gastric teratoma only in those cases who had not been operated or who had suffered hemorrhage and vomiting or reached the treatment moribund. A difficulty may arise in clinical diagnosis. It is so rarely encountered that in none of the reported cases gastric teratoma was diagnosed preoperatively. In our case the presence of irregular calcified areas in the X-ray was suggestive of teratoma, but its site of origin could only be ascertained on laparotomy.

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## Autoimmune Hemolytic Anemia—Mixed Type

A six-year-old girl was admitted with generalised weakness, recurrent episodes of palpitation with dyspnea and severe pallor. There was no history of blood loss or jaundice. She had received treatment for fever 6 days prior to admission. Examination revealed severe pallor but no icterus, petechiae or purpurae, puffiness or significant edema. Her firm liver spanned 12 cm and spleen was palpable 6 cm below the costal margin. There was moderate cardiomegaly, with a hemic murmur. The other systems were normal.

Blood examination showed: hemoglobin 4.5 g/dl, hematocrit 15%, reticulocyte count 4% (corrected 1.5), normal leukocyte and platelet counts. Liver functions, serum iron and iron binding capacity were normal. Direct and indirect Coomb's tests were strongly positive. Antibody studies revealed presence of both cold (4°C) and warm (37°C) antibodies both in enzyme and saline preparations. The serum