

surgical correction after birth, as there was no other anomaly. However, the baby died on the third postoperative day due to pulmonary complications.

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Gastric Teratoma Revealed by Gastrointestinal Hemorrhage

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Gastric teratoma, a very rare tumor of infancy usually presents with abdominal distension, palpable lump or vomiting(1). Its presentation as gastrointestinal bleeding is quite rare(2). We are reporting such a case because of its unique nature.

Case Report

A 10-year-old male neonate was admitted with complaints of abdominal distention since birth and malena of 2 days duration. There was no history suggestive of drug intake, trauma or perinatal stress.

Examination of child revealed a 3 kg neonate with severe pallor. Otherwise the general physical and systemic examination did not reveal any significant finding. Abdominal examination revealed an irregular surfaced lump, firm in consistency occupying epigastrium, left and right hypochondria and part of umbilical area. Rectal digital examination revealed malena.

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Nasogastric tube aspiration revealed 'coffee ground' aspirate. Baby was resuscitated and transfused. Plain X-ray abdomen showed calcification in a soft tissue mass in upper abdomen. Laparotomy under general anesthesia revealed a large tumor predominantly exogastric with a very small endogastric component which was bleeding, arising from greater curvature near fundus of stomach. Excision of tumor (Fig.) along with a rim of stomach (Sleeve resection) was done. Histopathology revealed benign histology. The patient is growing well 1 year after surgery.



Fig. Photograph showing excised specimen. The arrow is pointing to ulcerated endogastric component.

Discussion

Gastric teratoma is a very rare tumor of infancy. About 66 cases have been reported so far(2-5).

Majority of cases present with abdominal mass or distension or vomiting(1). Upper gastrointestinal tract bleeding due to gastric teratoma in a neonate is very rare(2). Only few cases have been reported with gastrointestinal bleed(2,6-8).

Investigation for gastrointestinal bleeding has led to the detection of gastric

teratomas(6). Majority of gastric teratomas presenting with upper gastrointestinal bleeding have been of endogastric type(1,7). Our case was unique not only due to presentation with malena but also because the tumor was predominantly exogastric with a small endogastric component.

Simple excision of teratoma in view of its benign nature is the treatment of choice(7), which was performed successfully in our case as well.

While dealing with an abdominal lump with gastrointestinal bleed in a neonate, one should keep in mind the remote possibility of a gastric teratoma as well. In such cases no amount of conservative treatment is going to help and surgical intervention is the treatment of choice.

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Total Intestinal Aganglionosis

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Total intestinal aganglionosis with absence of ganglion cells from duodenum to the rectum has been reported in thirteen cases in the literature prior to 1985 with uniformly fatal outcome(1,2). Senyuz *et al.* have reported a case of total intestinal

aganglionosis with involvement of the stomach(3). Absence of any satisfactory treatment makes it a unique but non salvageable form of intestinal aganglionosis. We report a case of total intestinal aganglionosis.

Case Report

A full term second born eight-day-old female child weighing 2.8 kg, presented with bilious vomiting and abdominal distention since the second day of life. She passed small amount of meconium on the third day of life. The other sib, a one-year-old boy, was normal. There was no family history of Hirschsprung's disease or any major congenital anomalies in the near relatives.

At hospital, the child passed small amount of meconium but continued to have bilious vomiting and progressively increasing abdominal distention with radiological evidence of low small bowel obstruction. At laparotomy the upper small intestinal loops were dilated with apparently narrowed terminal ileum, but cecum, appendix and rest of the colon were of normal calibre and there was no evidence of intrinsic obstruction. An end ileostomy proximal to the narrowed segment and distal ileal mucous fistula with biopsy from both the ends of bowel and appendectomy was performed.

The ileostomy did not function and the child remained obstructed. The histopathology revealed absence of ganglion cells in the appendix as well as both the stomas. An abdominal re-exploration and frozen section biopsy from multiple sites of the small intestine did not reveal any ganglion cells in the proximal intestine. A more proximal stoma was performed which did not function and the child died at 3 weeks of age.

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