



Fig. 1. Exposed posterior wall of the bladder with low lying umbilicus.

may be present. In females, clitoris is bifid and vagina can be identified underneath the urethral plate. Prenatal ultrasonography can sometimes help in diagnosis as early as the 12th week of gestation with characteristic absence of bladder, anterior abdominal mass and low-lying umbilicus. Examination of the baby is required in detail with documentation of the degree of exstrophy, size and pliability of mucosa, perineum, inguinal region, and anterior abdominal wall. Ultrasonography to rule out renal problem is a must.

There are two ways of repair: (1) multistage repair: In the multistaged repair, the closure of the bladder with or without osteotomy of both iliac bones just lateral to the sacroiliac joint. Later, bladder neck reconstruction is required; (2) single-stage repair. The single-stage procedure gives better results in terms of voiding and continence, but serious complication rate is higher as compared with that in the multistage procedure. In experienced hands, the result of multistage procedure is very good with low complications rate.⁴ I would like to acknowledge the help provided by Dr. B.C. Sharma for his valuable suggestions in finalizing this manuscript.

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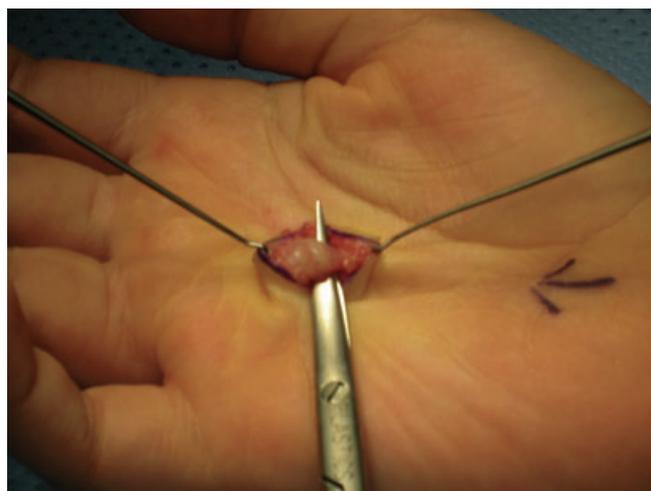


Fig. 1. Intra-operative view of palmar fibromatosis.

Dear Editor,

Paediatric Dupuytren's disease

This paper presents the first documented case of paediatric Dupuytren's disease in Australasia. An 8-year-old boy was referred by his general practitioner with a 6-month history of nodular mass in the right palm. There was no history of trauma. On examination, a 7-mm diameter mass was located in the right mid-palm between the palmar creases opposite the third web space. The mass was adherent to the overlying skin; however, the finger range of motion was preserved. Ultrasound reported a semi-cystic, semi-solid mass in the subcutaneous tissue. Surgical excision was performed to obtain a histological diagnosis. Intraoperatively the nodule was noted to be within the longitudinal cord of palmar fascia and had a macroscopic appearance typical of Dupuytren's disease (Fig. 1). Histology confirmed the diagnosis. The post-operative period was unremarkable and follow-up at 3 months revealed no evidence of recurrence.

Only six cases of histologically proven Dupuytren's disease have been reported worldwide in children under 10 years of age, including two infants aged 6 and 10 months.^{1–3} Fetsch identified a further two cases among a total of 56 cases of paediatric fibromatosis; however, patient age was not disclosed.⁴

Of the six cases, there was a male-to-female ratio of five to one, with a mean age at presentation of 4.8 years. Most common locations were the palm or little finger and fixed flexion deformities were present at the proximal interphalangeal joint in 60% of cases, with the deformity ranging from 20 to 50°. All cases were treated surgically, with five undergoing fasciectomy. To obtain up-to-date follow-up data we contacted clinicians of the above cases and obtained information on five patients. This revealed recurrence in only one patient, with follow-up ranging from 18 months to 5 years.

Recurrent Dupuytren's disease was originally reported in a second child; however, this was histologically misdiagnosed.³ A review of the original slides revealed epitheloid sarcoma, highlighting the care required when diagnosing recurrent disease in the paediatric age group. The presence of any atypical clinical or histological features is an indication for performing epitheloid

marker assays including cytokeratin 8 and 18 and epithelial membrane antigen.

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Dear Editor,

Managing suspicious cervical lymph nodes after thyroidectomy: the utility of hook-wire needle localization

Differentiated epithelial carcinomas of the thyroid, comprising papillary and follicular carcinomas, frequently concentrate iodine and are thus exquisitely sensitive to treatment with radioactive iodine. As such, while surgery is the modality of choice for the primary lesion, management of cervical nodes is less conclusive. While grossly involved cervical nodes require formal neck dissection, subclinical nodes that are suspicious for malignancy have become increasingly apparent with the use of high-resolution ultrasound. There is a lack of consensus as to whether radioiodine alone may be sufficient treatment or whether neck dissection is required,¹ with studies showing no difference in recurrence or survival in the presence of lymph node metastases.^{2,3}

Given this, we employ a unique approach to this scenario. For patients in whom there are no clinically palpable cervical lymph nodes, in the period between thyroidectomy and radioiodine treatment, we perform a screening ultrasound. Where there are any enlarged lymph nodes on ultrasound, these are selected for excision. As these are impalpable, operative localization is required. While popularized for use in breast cancer, the use of a hook-wire needle has not been widely used for neck lesions. We perform hook-wire localization preoperatively, and for three patients in whom this has been performed, there were no procedural complications, and the lesion was surgically excised with relative ease (see Fig. 1).

While problems with this technique may occur, including wire displacement or migration, when used for localizing thyroid cancer

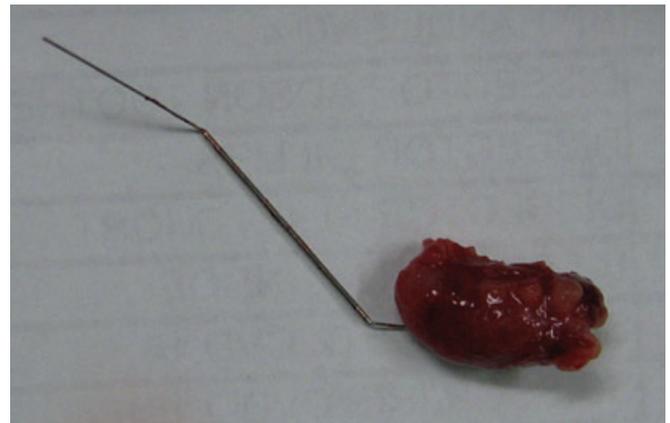


Fig. 1. Post-operative specimen photograph, demonstrating an excised enlarged cervical lymph node, with localization hook-wire needle attached.

recurrence⁴ or for intraoperative localization,⁵ these complications were not described. While there are other techniques available, such as carbon-tract or methylene blue localization and computed tomographic or magnetic resonance guidance, we have found ultrasound to be low-cost and widely available, and the technique of needle localisation to be safe and to aid surgical dissection and operative times. The use of this technique for selective nodal excision may improve outcomes from radioiodine therapy while minimizing the need for formal nodal dissections.

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