Atresia de coanas pediatria pdf

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Also reviewed are David Sive, MD, MHA, Medical Director, Brenda Conaway, Editorial Director, and A.D.A.M. Editorial Team. Traducci'n y localizaci'n realizada por: DrTango, Inc. Page 15Versi'n en ingl's revisada por: Michael M. Phillips, MD, Clinical Professor of Medicine, George Washington University School of Medicine, Washington, D.C. Also reviewed are David Sive, MD, MHA, Medical Director, Brenda Conaway, Editorial Director, and A.D.A.M. Editorial Team. Traducci'n y localizaci'n realizada por: DrTango, Inc. la obstrucci'n de las fosas nasales en el neonato es un cuadro potencialmente fatal pore su respiraci'n nasal obligada. La causa main es inflamatoria o infecciosa, y con menor frecuencia puede ser de origen cong'nito, neopl'sico, traum'tico o iatrog'nico. La Atrezia de Coanas es la anomaly congunite nasal mus comon. Una etiology menos frecuente de obstrucci'n nasal congenita es la estenosis de la aperture piriforme. Debe pensarse en esta 'ltima en todo reci'n nacido con cornaje y dificultad respiratoria de grado variable, asociado a la dificultad de pasar una sonda a trav's de la regi'an front de las fosas nasales. El Diagnosco se confirm por tomography computarizada del macizo craneofacial. La direza terapoutica recider de la mogdad de los Santomas. Describimos nuestra experiencia con 5 pacientes que presentaban esta afecci'n, tratados quir'rgicamente mediante abordaje sublabial y colocaci'n de tutor nasal. Estenosis congenita de la aperture piriformeNasal obstruction in newborns is a potentially fatal condition due to their exclusive nasal breathing. The main cause is inflammatory or infectious rhinitis. Congenital, neoplastic, traumatic or iatrogenic causes are less common. Choanal Atresia is the most common congenital nasal anomaly. Less common etiology of congenital nasal obstruction is pyriform diaphragm stenosis. Suspicion can occur in any newborn with varying degrees of stridor and respiratory failure associated with the difficulty of passing the probe through the front bunks. Diagnosis must be confirmed by CT scan Array. The therapeutic approach will depend on the severity of the symptoms. We Are We our experience with 5 patients with this condition, treatment surgically using a sub-laboratory approach and then nasal stenting. Congenital stenosis of the pyriform diaphragm Introduction of the pyriform opening (AP) is the most anterior and narrowed bone branch of the nostrils. His congenital stenosis is a rare cause of obstruction in a newborn, the result of excessive growth of the bones of the medial nasal process of the jawbone on a bilateral basis1.2. Incidence is unknown3. There may be isolated or associated with central traumatic brain or nervous malformations. The most common symptom is the cornice, which is the noise generated by the airflow disorder as it passes through a reduced caliber nostrils3. Other possible symptoms include shortness of breath, swallowing disorders, apnea and cyclic cyanosis, which improves with crying3.4. For physical examination there is an impossibility or difficulty of passing the tube behind the nasal lobby3. The diagnosis is confirmed by computed tomography (CT) of the traumatic brain array, where the reduction of the nasal area at the entrance level of the bones5.6.In the case of moderate to severe respiratory complexity, Swallowing disorder and rejection of conservative methods, treatment is surgical and consists of an expansion of the AP sublabial approach, a procedure that is safe and effective33 ,5.7.Clinical cases We represent 5 patients with congenital stenosis opening pyriform (ECAP), the treatment of the Children's Otolaryngological Service between October 2009 and May 2013 (table 1). Patients were born over the entire term and nasal obstructions from birth. A physical examination revealed a narrow nasal lobby and the inability to pass the K30 probe (2.8 mm diameter) into the nostril. The CT showed A.P. bone stenosis at the expense of both ascending branches of the jawbone, with a normal coan caliber, and in 3 patients, the central upper mega-roving (Figure 1). In all cases, the maximum transverse diameter of the AP was measured between the medial side of the jawbone at the level of the lower meat bone, in a folding section, an average of 4.82 mm (Figure 2). Two patients underwent a three-dimensional (3D) helithography scan that showed a decrease in nasal light. Resonant brain tomography MAGNETIC and genetic and endocrinological assessment were carried out. One patient has schizoencephaly, another has central diabetes, and the third has Pfeiffer syndrome (a rare genetic disorder characterized by craniosyness, moderate facial hypoplasia, syndactically and thick fingers). 5 patients were initially treated with decongestant and nasal steroids (phenylephrine and dexamethasone) for 10 days, with hydration and aspiration as needed, and fed them an augustic probe. Due to the severity of the symptoms and the failure of treatment, a surgical correction was resolved. Stable airways were obtained in all of them prior to the surgical treatment of McGovern pacifier. The surgical procedure consisted of expanding AP sub-labial access with the preservation of the nasal mucosa while milling the ascending jaw and pit floor. In all patients, the bilateral silicone tutor (endotrachal tube No. 3.5: an external diameter of 5.3 mm) was placed as an endonasal light support for 7 days (Figure 3). Feeding the Ohio probe was indicated before oral tolerance was tested and, during the nasal guardian's stay, nasal wash with saline through the tutor, the urge to excrete as needed and nasal mupirocin to avoid decubin lesions. An discharge from the hospital was provided between 7 and 10 post-operative days. Within 3 months of the enlargement surgery, the patient with Pfeiffer syndrome was tracheosthed with obstructive apnea. The average follow-up time was 22 months. Proper nose ventilation was achieved in 4 patients, with normal facial growth and age-appropriate nasal lobby size. The patient, with permeable nostrils, remains with glozoptosis of tracheostomy. DiscussionThe ECAP is a rare cause of nasal obstruction in newborns. Early diagnosis and proper treatment are essential because of your mandatory nasal breathing. The clinical presentation of bilateral coana stenosis and ECAP is similar, but stenosis and coanal atresia are more common and known3.3.In physical examination, anterior rhinoscopy is difficult

due to the low light observed by the medial projection of the mucosa covering the bone of the lateral wall of the nostrils. The introduction of the K30 suction probe (2.8 mm diameter) does not extend beyond 1 cm3. The diagnosis of certainty is made by a traumatic brain ct scans, where the diameter of the nasal area is observed to decrease at the AP level, while the koalas are of normal caliber. The transverse diameter of each pyriform hole less than 3 mm or a total transverse diameter of less than 11 mm in full-term newborns confirms the diagnosis1,5,8. Other radiological findings that are often associated are changes in teeth slitting (one central mega-shrewd) and triangular hard palate with a crest on midline5,6.3D tomography allows for a complete representation of the AP in the frontal plane, allowing it to measure its amplitude and accurately identifying the area of the bone to be dried2.3.Once inflammatory or infectious rinitis is excluded. Common nasal obstruction in newborns and infants, ECAP should be considered as a differential diagnosis, along with stenosis of coana or atresia, septum abnormalities, encephalocele and nasal tumors such as gliomas or dermoid cysts1-3.The presence of associated abnormalities should be studied by nasal endoscopy, brain MRI and genetic and endocrinological assessments. The association with mega-insive or single central jaw-cutting, holoprosencephaly, pituitary ageenesis, thyroid dysgenesis and chromosomal changes, among other things1,2,4,7-9.It is necessary to evaluate other areas of respiratory obstruction, muscle tone and the need for tracheostomy. One of our patients had a successful surgical correction of the nose, but decanulation could not be achieved due to glozoptosis. Therapeutic behavior will depend on respiratory failure and its effect on the development of infant weight5.First, safe airways should be installed by McGovern's nipple, oral cannula or oral intubation7. Tracheostomy is reserved for situations where other brain abnormalities are associated. Mild cases are treated conservatively with local decongestants and hydration until the nasal cavity grows and the blockage disappears3. When surgical treatment is indicated, the most accepted technique is to expand the AP through sub-labial access. Dissection and milling should be carried out to the lower root to prevent damage to the nasolacphrie duct. Damage to the nasal mucosa and teeth shoots on the floor should be prevented3.7. Subsequently, nasal guardians may or may not be placed. The use of sylesty intraluminal learning® was recommended during postoperative, to prevent reestenosis and promote irrigation of saline solution and the desire for secretions3.7.Although ECAP is rare, it should be included in differential diagnosis of respiratory obstruction in newborns and infants. Patients should be studied to identify possible related malformations. Surgical clinical treatment is based on the severity of symptoms. The authors state that they have no conflict of interest. The atresia de coanas pediatria pdf