A Toddler With Pain Abdomen and Pica: The 'Concrete' Evidence!

30-month-old boy presented with intermittent pain abdomen of three days duration. There was no fever, vomiting, diarrhea, dysuria or constipation. In between the episodes of pain, the child was comfortable. Vital signs and systemic examination, including per rectal examination, was normal. A plain X-ray abdomen in erect posture revealed multiple, radio-opaque shadows in the small intestine, colonic and the rectal area. The opacities were of different size and shape but of uniform density (Fig. 1). On further querying, mother admitted that the child has a habit of scrapping the old wall and eating small pieces of loose concrete material that used to fall off! The child was given liberal amount of oral fluids, soft diet, oral lactulose after hospital admission. After passage of stools thrice, on day 3, repeat X-ray abdomen showed complete clearance of the shadows. He had mild microcytic hypochromic anemia. Peripheral blood smear did not show any basophilic stippling. Blood lead assay could not be carried out. Parents were counselled regarding Pica and the provided behavioral modification advice. Child has been under regular follow up since then and is thriving well.

In our case, the morphology of opaque shadows along with the history given by mother helped in a 'concrete' diagnosis! As seen in this case, during follow up, such clear corroborative diagnosis can motivate the parents to ensure all the preventive steps to avoid consumption of such materials by the child again.

Fig. 1 Multiple opacities of varying shapes and sizes but of uniform density X-ray abdomen.

We share the typical X-ray picture to remind the readers of this common condition which is frequently overlooked.

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Bronchial Dieulafoy Disease with Recurrent Life-threatening Hemoptysis

Bronchial Dieulafoy's disease (BDD) denotes the presence of a vascular anomaly characterized by dilated, tortuous arteries in the bronchial submucosa, causing massive hemoptysis [1]. We present a child with life-threatening recurrent massive hemoptysis due to this disorder.

A 15-year-old boy, previously normal, had fainted after effortlessly expelling about 400 mL of blood and was intubated for airway protection. His hematological workup and coagulation and rheumatologic profile were normal. Upper gastrointestinal endoscopy demonstrated erosive gastritis, and he was treated for *H. pylori*. Ten days after discharge, he had an episode of drowsiness following a bout of cough with massive expectoration of blood. He was rushed to the emergency, where he was intubated, and received two units of packed cells.

Computed tomography of chest and pulmonary angiography showed patchy haziness in right lower lobe with no evidence of pulmonary embolism. He was referred to our hospital where he had a bout of massive hemoptysis and became limp. He was resuscitated, intubated, shifted to the pediatric intensive care unit and again required blood transfusion. Bronchoscopy revealed blood clots in right lower lobe. Broncho-alveolar lavage was negative for tuberculosis and fungal infections.

The clinical sequence of repeated massive life-threatening hemoptysis and blood clot on bronchoscopy was suggestive of bronchial artery pathology, possibly bronchial Dieulafoy disease. Selective aortography was done through right common femoral artery, a 4F cobra catheter was advanced into descending thoracic aorta. Selective embolization of hypertrophic tortuous right bronchial artery was performed using poly-vinyl alcohol (PVA) particles of 300-500 µm with complete disappearance of the abnormal right bronchial artery [2]. After embolization, the boy had no further hemoptysis and was doing well on follow-up after 6 months.