Infantile Hypertrophic Pyloric Stenosis; An Unusual Presentation

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Abstract
Infantile hypertrophic pyloric stenosis (IHPS) is a common cause of gastric outlet obstruction in infants [1], presenting with non-bilious projectile vomiting. The authors report a rare case of bilious vomiting in a neonate with intraoperatively diagnosed IHPS and no other gastrointestinal anomalies.

Abbreviations
IHPS: Infantile Hypertrophic Pyloric Stenosis;
US: Ultrasound

Introduction
IHPS is a common cause of gastric outlet obstruction in infants. The cardinal features of IHPS are non-bilious projectile vomiting and visible peristalsis in the left upper abdominal quadrant.

Bilious vomiting in this condition is rarely reported and may create confusions in diagnosis [2]. This is a report of a 30 days old infant with IHPS presenting with bilious vomiting and is intended to raise awareness and enhance index of suspicion.

Case Report
A 30 day old male infant, presented with one day history of non-projectile non bilious vomiting. There is no history of diarrhea, abdominal distension or fever. He does not have past history of recurrent vomiting or possets. He is exclusively breast fed and thriving well. He was born at term and had uneventful neonatal period.

On clinical examination, the patient was in a fair hydration status, afebrile and not jaundiced. His abdomen was soft and lax, none- distended, no masses felt and no visible peristalsis. The hernia orifices were intact and external genitalia were normal.

His blood investigations showed normal serum urea, electrolytes and glucose, normal full blood count and normal PH.

As his vomiting progressed on the second day of admission to bilious vomiting he went on to have abdominal US which showed evidence of pyloric stenosis with no evidence of bowel malrotation.

He underwent laparoscopic exploration which confirmed the pyloric stenosis and had Ramshtedt pyloromyotomy.

He had a full recovery and discharged on the third day post operatively.

Discussion
Bilious vomiting is rare in IHPS. It could be explained by vomiting through partially obstructed pyloric canal. In a series of 354 patients diagnosed with IHPS, 1.4% of them had bilious vomiting. The median pyloric muscle thickness on US was 3.6 mm which was significantly smaller than median thickness of 4.3 mm in those without bilious vomiting [2].

Seyi Olajide, et al. reported an 11 day old female neonate with bilious vomiting and exploratory laparotomy showed IHPS with pyloric thickness of 4.1 mm [3].

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Our patient had pyloric canal thickness of 4.1 mm as well.

US is a non-invasive, sensitive investigation in patients suspected to have pyloric stenosis and could be repeated as required.

With experienced sonographer, it has sensitivity and specificity of 95% [4, 5].

The normal serum electrolytes are due to earlier presentation and diagnosis [6, 7].

**Conclusion**

Bilious vomiting doesn’t exclude IHPS.

US is the modality of choice to diagnose IHPS [4, 5] and screen for any other associated anomalies, sparing the patient from the exposure to the risks of surgical exploration and/or radiation.

**References**


