Associate Pediatric Professions

1 UPS AND DOWNS OF PARENTAL COMPLIANCE

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Interaction between a patient (child) and expert is defined by the state of the patient's addiction and knowledge of all persons involved in their treatment, as well as the capacities of their caregivers. It is exceptionally important that none of these components are lacking, i.e. that mutual efforts focus on achieving the common goal which is the child's well-being. In order to ensure that, daily work with child patients is inseparable from establishing an alliance with parents. The lack of an encouraging (primarily familial) environment can have a disruptive effect on a child's development, confirming the importance of cooperating with parents who are pivotal allies in the treatment process.

If, for any reason, there is a lack of or interruption of parental cooperation, it can cause a higher risk of losing the patient or an inadequate approach towards the child's health issues. In order to avoid those outcomes, it is important to recognize and solve some of the potential obstacles.

In this paper we present different types of active and passive non-cooperation, observed in a continuum where negative and/or positive shifts can take place depending on various factors such as type and method of communication, respecting differences, timely reactions, and many other factors.

2 SOLITARY MASTOCYTOMA IN NEONATE MANIFESTING WITH SYSTEMIC SYMPTOMS

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Mastocytosis is a group of disorders characterized by excessive mast cell accumulation in the skin known as cutaneous mastocytosis (CM), or in extracutaneous organs in systemic mastocytosis (SM). Mast cells are a key component of the innate and adaptive immunity and are the main effector cells in allergy. Cutaneous solitary mastocytoma (CSM), the most common form of CM, presents as an indurated, erythematous, yellow-brown-reddish macule, papule, plaque or nodule with peau d'orange appearance and a rubbery consistency, measuring up to 5 cm in diameter. CSM may urticate or blister spontaneously or when stroked or rubbed (Darier sign) as a result of mast cell vasoactive mediator release (1).

8-week-old baby boy presented with 7 weeks history of erythematous-brownish infiltrated, nodular, rubbery, blistering, and growing lesion measuring 30x20mm in diameter on the dorsal lateral aspect of the left hand (figure 1).

Skin biopsy was performed and histopathology and immunohistochemistry (CD117 positive cells) confirmed a mastocytoma (figure 2). Recurrent febrile episodes started in early neonatal period followed by enterocolitis, acute bronchitis, nausea, and vomiting. Baseline laboratory investigations and abdominal ultrasound were normal. Serum tryptase was elevated on baseline and repeated blood tests.

Although systemic symptoms such as flushing, dyspnoea, hypotension, nausea, vomiting, and abdominal pain along with increased serum tryptase are more common in patients with SM, they can also occur in patients with SCM resulting from mechanical irritation of the lesion (2). This would explain some of the symptoms our patient experienced probably resulting from persistent activity of the lesion. Nevertheless recurrent febrile episodes and unprovoked elevated serum tryptase increased the risk of SM therefore patient was referred to oncologists for further assessment.

3 MODE OF DELIVERY AND PERINATAL OUTCOMES IN PREMATURE INFANTS WITH NEURODEVELOPMENTAL RISK FACTORS IN CROATIA IN 2018

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Investigate the association between mode of delivery and perinatal outcomes in premature infants with neurodevelopmental risk factors.

Using Croatian Institute of Public Health childbirth database records, outcomes of preterm infants born in 2018 and diagnosed with pathological conditions associated with neurodevelopmental risk were analysed with regard to mode of delivery (vaginal, caesarean section – CS). Common pathologic findings/conditions associated with neurodevelopmental risk included:

5-minute Apgar score below 7, intrapartum hypoxia or asphyxia, intracranial haemorrhage (grade 3 or 4) and pulmonary pathology (respiratory distress, pulmonary haemorrhage, pneumothorax, other respiratory disorders). In some premature infants, multiple neurodevelopmental risk factors were reported.

Other causes of morbidity were included in a common subgroup – Other entities. Data on early neonatal death (END) of premature infants caused by aforementioned conditions were also analysed.

In 2018, 2,232 premature infants were born in Croatia (6% of all live-births). Pathological conditions were reported in 1,926 (86.2%) preterm infants, whereof 430 (19.3%) were primarily diagnosed with entities related to neurodevelopmental risk. 5-minute Apgar score below 7 was observed in 176

(7.9%) children, whereof 68.2% were delivered by CS and 31.8% vaginally.

Hypoxia or asphyxia were the primary diagnosis in 33 (1.5%) and a secondary diagnosis in 107 (4.8%) children (140 in total – 6.3%); 58.6% were delivered by CS and 41.4% vaginally. Intracranial haemorrhage (grade 3 or 4) was the primary diagnosis in 19 (0.9%) children and a secondary diagnosis in 102 (4.6%), a total of 121 (5.4%); 92.5% were delivered by CS and 7.5% vaginally. Pulmonary disorders were the primary diagnosis in 378 (16.9%) children and a secondary diagnosis in 424 (19.0%) – a total of 802 (35.9%); 55.7% were born by CS and 44.3% vaginally. Other conditions were the primary cause of morbidity in 1,496 children (66.8%), whereof 50.5% were delivered by CS and 49.5% vaginally. Among 306 (13.7%) children recorded without any pathological condition, 41.5% were born by CS and 58.5% vaginally. Among 78 END cases, conditions related to