

Chronic axillary sinus in a child

Cholaraju Siva Ranadheer Raju¹, Suhitha Gajanthody², Ashraf Ahamed², Ameer Ali¹

From Departments of ¹General Surgery, ²Pediatric Surgery, Yenepoya Medical College Hospital, Mangalore, Karnataka, India

Correspondence to: Suhitha Gajanthody, Suprasada, 6th Cross, Lohith Nagar, Ashok Nagar Post, Mangalore - 575 006, Karnataka, India. E-mail: suhith1983@gmail.com

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ABSTRACT

Chronic discharging sinus in the axilla is of very rare occurrence in pediatric age. Such a presentation, especially with a previous history of trauma, should be viewed with caution. Various possibilities including tuberculosis are considered. Appropriate investigations and thorough wound management will help in the prevention of long-term morbidity. We report a case of the chronic discharging axillary sinus in a child and review literature.

Key words: *Discharging sinus, Foreign body, Painful shoulder*

Foreign bodies (FBs) in the axilla are very unusual. Wooden stick as FB is very rare and only limited cases have been reported in literature [1]. Usual presentation of FB in the axilla is a discharging sinus, which results due to the inflammatory reaction of the body to it. We describe a case of chronic axillary sinus due to a retained wooden stick in the axilla and review the current literature and management.

CASE REPORT

A 9-year-old male child presented with a discharging sinus in the right axilla for 3 months. There was pain on movement of the right shoulder. However, there were no anorexia, fever, chest pain, or cough. There was no history of contact with tuberculosis. A history of fall from a tree and laceration of right axilla was noted. Wound was primarily sutured.

Clinically, the child was adequately built and weighed 28 kg. There was a chronic sinus (1.5 cm×1.2 cm) in the right axilla with serosanguinous non-foul-smelling discharge (Fig. 1). Movements of the right shoulder joint were painful and restricted to minimal abduction and internal rotation.

Hematology and X-ray of the chest and right axilla were normal. Local ultrasonography revealed a sinus tract to a depth of 4 cm into the axilla with no involvement of the vessel and nerves. Exploration of the sinus tract was performed under general anesthesia which yielded a wooden stick stuck in the axilla measuring 3.5 cm×1 cm (Figs. 2 and 3). There was no granuloma around the FB. The wound was irrigated and closed with a corrugated drain *in situ*. The discharge was sent for culture which grew *Staphylococcus aureus* (methicillin resistant). Based on sensitivity, the child was given tablet Linezolid for a week.

The child had an uneventful post-operative recovery and was alleviated of the painful shoulder movements. He was further referred for physiotherapy to attain comprehensive shoulder

movements. The patient was followed up on 1, 3, and 6 months, postoperatively. Wound healed well and he was totally relieved of shoulder pain.

DISCUSSION

Retained FBs resulting from foreign materials accidentally left in a patient's body are a surgical complication [1]. Its incidence is estimated to be 1 in every 3000 procedures [2]. Retained vegetative foreign body in the axilla lacks literature. They may be completely asymptomatic or may develop complications which include abscess, sinus, fistula formation, and sepsis [3,4]. FB near tendons may result in tenosynovitis, and near to nerves may result in neuropathies. Arthropathies due to migration to joints and embolic events due to the involvement of veins are also reported [5].

Early exploration and adequate debridement of the wound with adequate coverage of antibiotics are crucial factors in curtailing morbidity and mortality rate [6]. When wooden FB is suspected,



Figure 1: Discharging sinus in right axilla

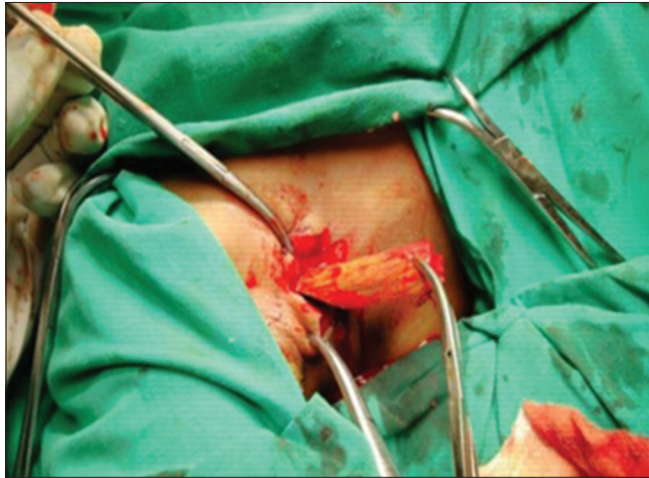


Figure 2: Intra operative picture



Figure 3: Retrieved foreign body

ultrasound is the best modality, as radiography is often unyielding. Hyperechoic appearance with posterior shadowing confirms FB [7]. However, when ultrasound is insufficient, air density displayed on the computed tomography or susceptibility artifact in a magnetic resonance imaging study would be beneficial [8].

The differential diagnosis for a discharging sinus in the axilla should be made which includes tuberculosis lymphadenitis, hidradenitis suppurativa, and pilonidal sinus as reported by Sengul *et al.* [9] and Stanley and Granick [10].

CONCLUSION

A high degree of suspicion during primary management of traumatic wounds and complete removal of FBs with adequate post-procedure antibiotics and tetanus toxoids goes a long way in minimizing the complications and the related morbidity and mortality.

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