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## Pectus excavatum deformity ct

Pectus Excavatum Deformation General considerations Congenital sternum deformities and 4 to 5 front ribs, which led to funnel shape or sunken anthrone wall The most common chest wall abnormality Male: female ratio 3:1 Most cases are seen at birth and 90% by age 1 Familial in 35% Also Related to Marfan and Poland Clinical Findings Most of them asymptomatic may be associated with mitral valve prolapse in 20-40% Pulmonary Function Tests May Show Restrictive Pattern Imaging Results Posterior Displacement Results Lower Sternum Down Optic Rib Angulation Visible Cardiomegaly Caused by Heart Compression Lack of Normal Right Front Shadow To The Right Of Lower Thoracic Spine Treatment Ratio Of Chest Transverse Diameter Division to Anterior Diameter Over 3.2 (Galer Index) May Be Indications , now often performed laparoscopically and uses low-invasive surgery More accurate chest measurements can be obtained via CT scan than conventional X-ray Pectus Excavatum Deformity. On the frontal projection there is an accented, descending orientation of the lower front ribs (red arrow). The heart appears enlarged, but part of this appearance is the result of a compression of the heart, better visible on the side gaze. The boundary of the right heart is fuzzy. On the side look, the lower sternum is depressed inward (white arrow), squeezing the heart between it and the spine. The excavator Pectus Andre Hebra, an MD eMedicine Pectus excavator also known as chest funnel or trichterbrust 13, is a congenital chest wall deformity characterized by concave sternum depression that led to cosmetic and radiographic changes. This is the most common chest wall deformation, representing approximately 90% of cases, occurs up to 1 in 300-1,000 births and is more common in men (M:F = 3:1) 1.4. The opposite deformity is known as pectus carinatum (pigeon chest). Although usually objectively asymptomatic, many patients report perceiving a failure to maintain physical activity. This is often due to significant body image problems, which can have serious consequences for affected 4 children. Aside from the obvious cosmetic and psychological issues, the pectus excavator is also sometimes associated with: While most sporadic ones can be seen in association with: Characteristically demonstrates: blurring the right heart boundary (PA/AP film) increasing lung infertility area density 5 horizontally rib vertical front ribs (heart-shaped) heart displacement towards left obliteration of descending aortic interface 5 cardiac silhouette expansion due to heart compression (FILM PA/AP) sharply defined and more vertically oriented medial breast boundaries in women, chest media field sign 12 diagnosis is evident in a CT scan with a degree of deformity and mediastal displacement is often dramatic. The Haller Index (HI) (maximum transverse diameter/mildest AP length of the chest) is used to assess the severity of the percussion of the sternum in the mediastinum. The usual Haller index is 2.5. A significant excavator of pect has an indicator greater than 3.25, which represents the standard for determining the candidacy for repair. The depression index is calculated by identifying the point of maximum sternum depression on a CT scan and then drawing a line through the most constricted ribs. This index uses vertebral body diameter as correlated with human size to help normalize body size and variable soft tissue thickness. The measurement is then taken from the middle of the sternum perpendicular to this line. This skeletal sternal depression then divides the transverse diameter of the spinal body at this level of 9. Correction index (CI) requires drawing a horizontal line across the front of the spine. Then two distances are measured: the minimum distance between the posterior sternum and the anterior spine, as used for HI, and the maximum distance between the line placed on the front black spine and the internal margin of the foreman of the chest itself. The difference between the two lines is simply the amount of defect the patient has in his chest. If this difference between measurements is then divided by the maximum popularity of the chest (the longer the measurement) and multiplied by 100, it generates a percentage of chest depth that the patient is absent centrally. Conversely, it represents a percentage of chest depth that needs to be corrected by placing a bar, or a correction index of 10. The angle of sternum tilt is an important morphological criterion to be noted for each patient with a pect excavator. This is measured in the axial plane, taking the axis angle of the mediolateral length to horizontal. Torsion, measured at an angle of more than 30° is considered severe, while mild torso is applied to any angle of less than 30°11. Although historically most cases have not been treated, and early studies have shown that even in extreme cases repair does not offer a significant improvement in respiratory functional tests 2 recently symptomatic improvements in ventilation and perfusion scans, as well as numerous other symptoms, have been described 3,7,8. Importantly, contrary to earlier beliefs, pect deformations often persist into adulthood, and symptoms can become more pronounced 8. In addition to symptoms, negative effects on body image and normal psychological development should also not be underestimated 4. Surgical options include inserting a metal bar, rib osteotomy, disabling the sternum from expensive cartilage and even reversal of the sternum 2. The NUSS procedure is a low-invasive procedure where is inserted subconsciously. He largely replaced the Ravitch procedure, which was considerably more invasive. For an uninformed excavator, pectus can be troublesome on the windshield x-rays of the chest. Various signs include: Diagnosis is evident on lateral projection, and of course transverse imaging 1. Dähnert W. Radiology Review Guide. Lippincott Williams and Wilkins. (2007) ISBN:0781738954. Read it in Google Books – Find it on Amazon 2. Wheeler R, Foote K. Pectus excavator: studiously ignored in the United Kingdom? 2000;82 (3): 187-8. doi:10.1136/adc.82.3.187 - Free text on pubmed - Pubmed cit 3. Blickman JG, Rosen PR, Welch KJ and others. Excavator of pectus in children: pulmonary scintigraphy before and after corrective surgery. Radiology. 1985;156 (3): 781-2. Radiology (abstract) - Pubmed citation 4. Kelly RE, Cash TF, Shamberger RC, etc. Surgical repair of the excavator of pect significantly improves the image of the body and perceived the ability to physical activity: multicenter research. 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(2020) British Journal of Radiology. doi:10.1259/bjr.20150595 - The Children's Chest Wall Warr Center in Connecticut treats pediatric patients affected by the excavator of Pectus, Pectus Carinatum and other chest wall deformities. Connecticut Children's is the only children's hospital in the state that offers a center dedicated to chest wall deformations. The center includes specialists and medical professionals from Connecticut Pediatric Cardiology, Pulmonary, Orthopedics, Pain Management and Radiology Departments to ensure the highest quality of care. What is a Pectus excavator? Pectus Excavatum is a depression of sternum and lower expensive cartilage. It is the most common congenital chest abnormality in children, often found at birth or during the first year of life. Over time, children with the Pectus excavator may notice restrictions on normal exercise due to chest restrictions, which keeps the lungs from fully expanding. Children can also become self-edged. Excavator treatment Pediatric treatment of pediatric patients with any degree of chest deformity is carefully evaluated at the beginning of deformity and in adolescence. A thorough assessment of the child's condition will determine the most appropriate treatment option. When chest indentation exceeds 2.5 centimeters, internal changes are likely to occur and surgery may be required. Connecticut pediatric surgeons use the Nuss procedure, which is a low-invasive surgical technique for correcting the Pectus excavator. During the procedure, a steel bar is placed behind the sternum. The bar remains in place for a minimum of three years to correct the condition. Connecticut Children have performed the Nus procedure and other chest wall procedures for nearly 40 years. Our team

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