Vomiting is common in children. The causes range from simple to complex and possibly fatal. The clinician would face multiple common and benign cases related to overfeeding, gastroesophageal reflux and gastrointestinal infections. However, diagnostic difficulty could occur when the underlying cause is an intracranial pathology, a metabolic abnormality or a structural anomaly of the pylorus or duodenum.

Intestinal obstruction is a congenital phenomenon which occasionally presents in association with other congenital anomalies, and could be either intrinsic or extrinsic. Extrinsic causes include malrotation, Ladd’s bands, and annular pancreas, while intrinsic include duodenal atresia, stenosis or web.

The aim of this presentation is to report a rare and uncommon presentation of a delayed duodenal obstruction caused by a windsock deformity.

**THE CASE**

A two-year-old Indonesian female presented with a history of recurrent vomiting during the last 6 weeks. The vomiting had increased in frequency over the previous five days, and the child was unable to tolerate any oral diet. The vomiting was described as large in amount and bilious and was associated with 2 kg loss of weight in two weeks. She had not responded to antiemetic medication and fluid rehydration therapy. History revealed recent travel to Indonesia where her symptoms began, but no further relevant details were relevant. The child had an uneventful peripartum period followed by a normal delivery; no vomiting or any other medical symptoms in the neonatal period were revealed.

On examination, the child was in a mild state of shock with fluid deficit of five percent causing hypoactivity and mild tachycardia. Blood pressure, temperature and capillary refill time were within normal limits. Her weight for age was four standard deviations below the normal limits. Inspection of the abdomen showed active and visible peristaltic movement; however, palpation revealed no organomegaly or tenderness.

Bolus intravenous fluids were administered to resuscitate the patient, and an initial blood gas analysis showed a mixed respiratory and metabolic alkalosis, hypokalemia and mild hyponatremia. Abdominal plain film radiograph showed a markedly distended stomach with an air-fluid level; however, air was seen tracking all the way to the rectum and no distended bowel loops were noted, see figures 1 and 2. An abdominal ultrasound showed a dilated common bile duct with minimal intrahepatic biliary dilatation.

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**The Uncommon Diagnosis of Windsock Deformity for a Common Presentation**

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We report a two-year-old Indonesian female who presented with vomiting and weight loss for more than one month and was ultimately diagnosed with duodenal obstruction due to a windsock deformity. This is a rare and intrinsic congenital anomaly of the duodenum. The diagnosis as well as immediate and conclusive surgical management is discussed.


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Figure 1: Preoperative Lateral Abdominal X-ray Showing Distended Stomach