Sir,

Germ-cell tumors are the most common ovarian neoplasms in the first two decades of life.[1] Sex cord–stromal tumors (SCSTs) are a rare class of ovarian tumors associated with androgen and estrogen excess, resulting in virilism, hirsutism, amenorrhea, or precocious puberty. They account for <0.5% of all primary ovarian tumors.[2] Sertoli–Leydig cell tumor (SLCT) and granulosa cell tumors (GCTs) are two subtypes of SCSTs associated with similar clinical presentation. SLCT is usually seen in females of reproductive age group (second and third decades of life). Precocious puberty in children younger than 10 years of age is rarely due to SLCT and is mainly attributed to juvenile type of GCT (JGCT).[2,3] Bhattacharyya et al.[1] in their study comprising 151 ovarian tumors in a pediatric age group encountered only one case of SLCT. A 12-month-old female child presented to the pediatric department with complaints of abdominal fullness, breast, and pubic hair development. Ultrasonography revealed a right side pelvic mass. Serum testosterone levels were elevated (20.54 ng/ml [0.2–1.2]). All other biochemical and hematological investigations were unremarkable. Exploratory laparotomy revealed a right ovarian mass, oophorectomy was done, and the mass was sent for histopathological examination. Right side fallopian tube, left adnexa, and uterus were preserved. No extra-ovarian focus of disease was identified. Grossly, the ovary was well encapsulated and measured 10.5 cm × 10.0 × cm 9.0 cm. On cutting open, hemorrhagic fluid came out. The cut surface revealed both cystic and solid areas. The cysts varied in size from 0.8 to 4.0 cm and were predominantly seen in the central region. Solid component was compressed at the periphery and had a homogenous appearance. Light microscopic examination revealed a tumor arranged in solid and trabecular pattern at the periphery. Tubules and cords along with cystic spaces and necrosis were seen toward the center. Cells were small to
medium in size and cuboidal to columnar in shape; showed pleomorphism; and had scant cytoplasm, hyperchromatic nuclei with occasional grooving, and inconspicuous to small prominent nucleoli and brisk mitoses. These cells were morphologically consistent with Sertoli cells. Interspersed in between these cells was seen a second population of cells arranged in nests and having abundant clear to pale granular cytoplasm with round monomorphic looking nuclei, morphologically consistent with Leydig cells [Figure 1]. Stroma was fibromyxoid. Based on these histological findings and clinical symptoms, a diagnosis of SCST favoring a poorly differentiated Sertoli–Leydig cell tumor (PDSLCT) was offered. Eight weeks postsurgery, the patient’s breasts became less prominent and the pubic hair had disappeared. Any further treatment such as chemotherapy was refused by the parents due to financial constraints and the patient was lost to follow-up. Stage and degree of differentiation are the most important prognostic factors in SLCTs. Around 59% of poorly differentiated tumors have a malignant behavior and are found to occur in an average 10 years younger patients in comparison to well-differentiated tumors which are 100% benign and occur commonly in adults. The main differential diagnosis of SLCT in this age group is JGCT. Follicular pattern, single population of large round to oval cells exhibiting marked pleomorphism, mitotic activity, and a fibrothecomatous background favor JGCT. JGCT has a favorable prognosis over PDSLCTs. Because of similarity in clinical presentation, histology proves to be of great help in diagnosis. The authors also suggest that frozen tissue examination and intraoperative aspiration cytology, though not much practiced in gynecology, can prove to be helpful in determining the tumor type, so that extent of surgery and tumor stage can be determined, keeping in mind that PDSLCTs can also occur in this age group and is an important differential diagnosis of JGCT.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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Sir,

A 2.5‑year‑old boy was admitted to the hospital with a history of foreign‑body aspiration. During the bronchoscopic investigation, a 3‑cm chicken bone was observed in the right mainstem bronchus [Figure 1]. Due to friable nature of the object, the author decided to use a cryoprobe for extraction. The object was successfully extracted. Only few case reports have examined the safety and efficacy of this method in children.

To the best of the author's knowledge, the index case is the first pediatric patient with a big missed chicken bone aspiration, managed by cryoextraction with a flexible bronchoscope.

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