SELECTED ABSTRACTS

The experience of the authors with six patients who had injuries to the duodenum is reported upon. One of the six patients had a gunshot wound with penetration of the transverse portion of the duodenum and an associated penetrating wound of the stomach. The other five patients sustained injury to the duodenum after blunt trauma; the associated injuries included lacerations of the liver and contusion of the pancreas, perforation of jejunum, contusion and perforation of transverse colon, disruption of abdominal wall, contusion of the brainstem, injury to the chest and laceration of the gastric serosa.
The patient with a gunshot wound was treated with local duodenal repair. Other patients were treated with duodenal repair, jejunostomy and partial gastrectomy plus Biliroth II reconstruction. The patient with laceration of the liver and contusion of the head of the pancreas underwent repair of the hepatic laceration and drainage of the common bile duct and of the pancreas head.
Four types of duodenal injuries and appropriate treatment for each are suggested by the authors. First, giant hematoma caused by blunt trauma to the abdomen is treated by transverse incision in the seromuscular cord at the lower margin of the hematoma, removal of clot followed by hemostasis and closure of the incision. Second, small penetrating wound is closed transversely in two layers. Third, complete or partial disruption is treated with end-to-end anastomosis or Roux-en-Y duodenojejunostomy; side -to-side jejuno-jejunal anastomosis may be indicated in some instances. Fourth, patients with a large defect in the descending portion of the six patients in this series survived. The only patient who died had severe contusion of the brainstem and crush injury to the chest.
Nikhilesh Agarwal

Colorectal Linitis Plastica. Turlapati R. Rao, Ernestine Harnbrick, Herand Abcarian and others. Dis. Colon Rectum, 1982,25:239-244.
IN THIS REPORT, the authors outline their experience with primary linitis plastica of the colon and rectum. Twenty-two patients who were referred because of a variety of clinical manifestations ranging from rectal bleeding to intestinal obstruction are included in the study. The disease is discussed from a diagnostic and, therefore, therapeutic point of view which is highlighted by tkree detailed patient reports. Radiologic features of the disease and histologic characteristics are discussed in detail.
It is concluded that this is a disease of younger patients in which the diagnosis is usually made by exclusion. The authors point out that deep biopsies are necesssary for diagnosis and the ulcerative colitis may be coexistent. They also point out that adequate surgical resection in the treatment of choice, accompanied by resection of the ovaries in women. Finally, it is noted that no patients with this disease who survived for five years have been reported upon.
Joseph A. Caprini

Follow-up Procedure for Carcinoma of the Colon and Rectum (Tumornachkontroile beim kolorektalen Karzinom) U. Metzger, K. Schneider, P. Buchniann and F. Largiader. Praxis, 1982, 71:327-331.
The purpose of follow-up procedures of patients with cancer who have undergone curative operation is the early detection of recurrences which may still be curable. Systematic follow-up study requires a certain discipline on the part of the patients. About one-half of the patients treated at the Zurich University Surgical Clinic in Switzerland are capable of co-operating with a follow-up protocol. Before these patients undergo operation, a history is taken and a physical examination, examination of stools for occult blood, a carcinoembryonic antigen titer, chest plate, liver scan and either a computed tomographic or an ultrasonographic examination, proctoscopic and colonscopic procedures or barium

enema are done. Three months after operation, determination of carcinoembryonic antigen titer is repeated and a hemoccult test and proctoscopic procedure are done for low-lying anastomoses. The same procedures are done in addition to a liver scan or a computed tomographic or an ultrasonographic examination, proctoscopic and colonscopic procedures or barium enema are done. Three months after operation, determination of carcinoembryonic antigen titer is repeated and a hemoccult test and proctoscopic procedure are done for low-lying anastomoses. The same procedures are done in addition to a liver scan or a computed tomographic or ultrasonographic examination six months after operation. Twelve months postoperatively, all of the procedures are repeated. The protocol extends to 60 months and is intended as a guide for the family practitioners who are observing the patients with carcinoma of the colon and rectum during the follow-up period. The protocol takes into account the biologic characteristics of primary and recurrent tumors and has a reasonable cost-benefit relationship.
High carcinoembryonic antigen tiler values preoperatively and the failure of values to fall to normal postoperatively are unfavourable signs. An elevation of carcinoembryonic antigen value after operation indicates a recurrence of tumor 90 per cent of the time; however, normal values in the postoperative period do not absolutely exclude recurrences of tumor.
William B. Gallagher

Controlled Trial of YAG Laser Treatment of Upper Digestive Hemorrhage. P. Rutgeerts, G. Vantrappen, L. Broeckaert and others. Gastroenterology, 1982, 83:410416.
A CONTROLLED TRIAL was done of laser treatment of 129 patients with bleeding of the upper gastrointestinal tract. The neodymium-yttrium-aluminum-garnet laser was used to treat a randomly selected group of patients with bleeding of the gastrointestinal tract. The patients were selected at endoscopic examination and then randomly assigned to be treated or no, according to the selected protocol. Another surgeon observed the patients for a follow-up period and decided whether or not operation was necessary without knowledge of the previous treatment status of the patient. Treatment with the laser did decrease the necessity of operation; however, it did not alter the mortality of the patients. The long term follow-up results are unknown.
An additional uncontrolled group of patients with unstable conditions and active bleeding was also studied. An impressive 87 per cent of the patients in this group were treated effectively. Although 55 per cent rebled, the treatment allowed interval time for stabilization and preparation for operation.
Walter Rohlfing III

Anti-Inflammatory Drugs and Bleeding of the Digestive Tract; Natural History and Diagnosis (Anti-inflammatoires et hemorragie digestive: Histoire naturelle et diagnostic) M. De Reuck, A. De Vos. A. Burette and others. Acta Gastroenterol. Beig., 1982,45: 9-17.
FROM January 1976 to June 1981, the authors performed more than 6,000 endoscopic procedures of the upper intestinal tract, 711 of which were indicated by hemorrhage. A study was done of three groups of 100 patients each. Group 1 consisted of those patients who had acute hemorrhage of the upper gastrointestinal tract and were receiving anti-inflammatory drugs. These patients were compared with those in group 2, patients with hemorrhage of the upper gastrointestinal tract but receiving no anti-inflammatory drugs, and those in group 3, patients receiving anti-inflammatory drugs who had digestive complaints attributable to the medication but no bleeding.
The most common lesion in all groups of patients was gastric ulcer; gastritis and duodenal ulcer were common but less frequent. Ulcerated esophagitis, esophageal varices, Mallory-Weiss syndrome and duodenitis occurred less frequently, and the least common lesions were tumors of the upper gastrointestinal tract. The incidence of focal gastroduodenal ulcer and a history of previous peptic ulcer disease were higher among patients in group 1 than those in the two other groups. The number of patients requiring surgical intervention was approximately the same in all three groups.
The incidence of various lesions in the upper gastrointestinal tract observed in 100 patients receiving

anti-inflammatory drugs was further analyzed according to whether the patient was receiving steroidal, nonsteroidal drugs or a combination of both. Those receiving nonsteroidal anti-inflammatory drugs had a significantly higher incidence of gatric uler. Those receiving a combination of steroidal and non-steroidal anti-inflammatory agents had a significantly higher incidence of Mallory-Weiss syndrome and erosive gastritis than those receiving either steroidal or nonsteroidal drugs alone. It is concluded that, before beginning anti.inflammatory management, an endoscopic examination of the upper gastro-intestinal tract is useful-particularly for patients with a previous history of gastroduodenal ulcer.
Frederick W. Preston

Malignant Lymphoma in the Residual Stomach Mter Gastrectomy; a Case Report. Takaaki Sudo, Sei Shiraha, Kenji Ishlyama and others. Jpn. J. Surg., 1982, 12:270-273.
THE AUTHORS present a report of a 25 year old Japanese man who had primary malignant lymphoma develop in the residual stomach 16 years after undergoing a Biiroth II gastrectomy for duodenal ulcer. The patient had been asymptomatic for 16 years and was admitted to the hospital complaining of epigastric pain and a weight loss of 2 to 3 kgm. Results of fiber gastroscopic examination revealed Borrmann type 2 changes in both the anterior wall of the stomach and the lesser curvature of the posterior wall of the residual stomach. Laparotomy and subsequent total gastrectomy, including resection of the pancreatic tail and spleen, and dissection of the lymph nodes were performed. The ed specimens showed four Borrmann type 2 tumors. The diagnosis was malignant lymphoma of a diffuse histiocytic type.
A review of the literature revealed data upon seven patients in Japan with nonepithelial malignant lymphoma. Four of these instances developed after Biiroth I or II procedures were done, and all but one instance occurred one to 14 years after surgical treatment for gastric or duodenal ulcer.
Judith S. de Nuno

The Problem of Congenital Duodenal Obstruction; a Report of 123 Patients (Zur Problematik des kongenitalen Duodenal-verschiusses -Bericht uber 123 Falle). R. Daum, H. Roth, B. Schuler and M.Bolkenius. Z. Kinderchir., 1982, 35:125-129.
BETWEEN 1962 and 1980 at Heidelberg, Germany, 46 boys and 54 girls were operated upon for congenital duodenal obstruction. Seventy-eight of the 123 children had extrinsic obstruction: 65 had mairotation of the colon, and 13 had annular pancreas. Forty-five patients had intrinsic obstruction:23 had membranous stenosis, and 22 had complete atresia. Seventy-four of the children, 60 per cent, were mature at birth and had no further malformations. Twenty-five mature children and 11 who were premature at birth had additional malformations.
Gastroenterostomy is obsolete for the operative correction of congenital duodenal obstruction. Mairotations should be corrected, but opinions differ about the necessity of fixation. Instances of annular pancreas and complete duodenal atresia are treated by duodenoduodenostomy; the proximal dilated segment is opened transversely, the distal collapsed segment is opened longitudinally, and they are anastomosed obliquely around the occluded or absent segment.
Membranous atresias or stenoses are treated by longitudinal duodenotomy, partial excision of the membrane, with care being taken to identify the ampulla of Vater. The excised area of the membrane does not need to be oversewn. The duodenotomy is closed transversely. Between 1962 and 1972, the mortality was 25 per cent. None of the 54 children who have been operated upon since 1972 has died.
William B. Gallagher

Influence of Surgical Techniques on Survival in Patients with Colorectal Cancer; a Review. Paul H.Sugarbaker and Scott Corlew. Dis. Colon Rectum, 1982, 25: 545 -557.
THIS REVIEW was undertaken in an attempt to accumulate and critically evaluate all evidence suggesting that special techniques may alter survlval rates of patients undergoing operation for

carcinoma of the large intestine. Data suggesting reduced survival times when a distal margin of resection less than 5 cm. was present in patients undergoing anterior resection were found to be inconsistent. En bloc removal of the primary tumor and an adhesed adjacent structure seemed important, for survival rates of 30 to 60 per cent have been reported with the use of this approach, and adhesions were found to contain malignant cells at the interface of the primary tumor and the adjacent structure in 40 to 100 per cent of patients.

No, statistically significant differences in survival rates were found when conservative segmental intestinal resection was compared with radical hemicolectomy. This finding was true for resections of the colon as well as the rectum; while patient morbidity was not markedly increased for radical colectomy, it was found to be much greater with radical resections of the rectum. Data to support the use of "no-touch techniques" for control of intraluminal tumor cells were sparse; however,, the authors conclude that, because these maneuvers cost the patient little in terms of added morbidity, they should be used.

Orville F. Grimes

Incubator Radiographic Diagnosis of Intestinal Perforation in the Newborn. M. Grunebaum. Ch. Horodmecanu, N. Ziv and others. Z. Kinderchir., 1982, 36: 97-99.

A TECHNIQUE for roentgenographic study of neonates who are suspected of having intestinal perforations is described. Roentgenograms are taken of the neonates in their incubators without disconnecting them from complex support and monitoring equipment.

Vertical and cross incubator roentgenograms of the abdomen were taken of 24 infants ranging in gestational age from 26 to 40 weeks. The following roentgenographic findings were thought to be signs of intestinal perforation: a circumscribed lucent area over the liver; increased lucency over the diaphragm; a cresent shaped lucency along the anterior-superior hepatic border, and a triangular lucent formation below the anterior abdominal wall between intestinal loops. It is concluded that this method is preferable to others for the evaluation of air under the diaphragm in neonates because the infants need not be moved and because no waiting is necessary to allow air to rise after a position change.

Jane F. Goldthorn