# SELECTED ABSTRACTS



**Diagnosis and Treatment of the Rupture of the Lateral Malleolar Ligament (Diagnostik and Therapie der lateralen Bandrouptur am oberen Sprunggelenk). U, Schutze, T. Mischkowsky, V. Gotze and H. Amberger. Z. Kinderchir., 1982, 36: 128-130.**

THE MANAGEMENT of 22 patients with rupture of the lateral malleolar ligament is described. Only results of roentgenographic examination with fixed talar drawer position exclude the presence of instability with certainty. Roentgenographic exposure is done with 15 to 20 degrees internal rotation of the lower portion of the leg and 30 degrees plantar flexion of the foot, with subluxation forward thrust of the talus extending the fib ulotalar joint space.

The indications for surgical procedures are considerable, instability of the ankle joint compared with that of the healthy side, a suspected covering of one periosteum or ligament as an interposition and a suspected lesion of the cartilage of flake fracture. Twelve of 22 surgically treated children showed injury to the anterior fibulotalar ligament, and eight had rupture of the fibulocalcaneal ligament. Although cast immobilization is often sufficient, surgical repair is recommended in the presence of flake fractures or interposition of soft tissue.

**Ernest H Bettmann**

**Inflammatory Diseases of the Spine (Entzundliche Erkrankungen der Wirbelsaule). A Gob. Chirurg, 1982,53: 299-305.**

MOST instances of acute and chronic osteomyelitis of the spine are caused by Staphylococcus aureus, Streptococcus viridans and pyogenesis, with 30 per cent nonspecific involvement. Primary foci are the pelvis, the urogenital tract and sometimes, after prostatectomy in men and septic abortions in women, the area between lower dorsal and upper lumbar segments. Diabetes is a predisposing factor. High sedimen tation rates and leukocytosis are typical findings. A paravertebral abscess shadow may be demonstrable roentgenographically at an early stage; narrowing of the intervertebral disc spaces may appear only after two to three months. Myelographic examination is indicated when there is neurologic involvement. Computed axial tomographic scans and scintigrams enhhance early diagnosis, and an aspiration biopsy procedure is recommended.

Complications include meningitis, paraplegia, the possibility of retropharyngeal abscess and perforation of an abscess into the hip joint or sacroiliac segment. Laminectomy in the presence of larger vertebral defects may enhance ventral instability. The latent period of tuberculous spondylitis extends from several months to three years. In children, it is localized in the vertebrae, and in adults, the intervertebral discs are involvecL Conservative treatment in the spondylitis of more than eight months duration consists of plaster shell immobifization combined with the administration of streptomycin, isoniazid and Myambotol, ethambutol hydrochloride, over a period of two years.. Surgical methods are absolutely indicated in the presence of damage to the spinal cord and large abscesses. Costotransversctomy or the transabdominal or retroperitoneal approach is used with possible complications, such as kidney infection, paralytic ileus or, after transthoracic approach, emphysema or hemothorax. The need for repeated roentgenographic control is stressed.

**Ernest H Bettmann**

**Correction of Postburn Syndactyly; an Analysis of Children with Introduction of the YM-Plasty and Postoperative Pressure Inserts. J. Wesley Alexander, Bruce G. Macmillan and Linda Martel. Plast. Reconstr. Suig., 1982, 70: 345-354.**

ONE HUNDRED AND NINETY PROCEDURES performed for correction of syndactyly after burn

were reviewed retrospectively. The results of the review document the need for improved reconstruction of this defect. AVM-plasty technique for correction of postburn syndactyly was evaluated in the treatment of 24 such deformities. This method is advocated for the treatment of volar or dorsal webs without limitation of movement at or beyond the metacarpophalangeal joint. Skin grafts are usually required for complete correction of the syndactyly with such limitation of movement. Web insert appliances proved to be a useful adjunct to surgical therapy.
**John Bostwick III**

**Double-Blind Controlled Trial of Indomethacin as an Adjunct to Narcotic Analgesia After Major Abdominal Surgery. P.G. Reasbeck, M. L. Rice and J.C. Reasbeck. Kancet, 1982, 2: 115-118.**
THE DIFFICULTIES of postoperative narcotics are well-recognized, and it is always worthwhile to seek therapeutic measures which might reduce the requirement for these compounds. In this study, the effect of the anti-inflammatory drug indomethacin upon the requirement for morphine in patients after undergoing laparotomy or thoracolaparotomy is assessed. Patients were excluded if they had a prior history of a bleeding diathesis or peptic ulcer disease.
Ninety-five patients were entered into the trial, and five were withdrawn because of failure to adhere to the protocol. The patients were selected randomly to receive either 100 mgm. of indomethacin as a suppository every eight hours or a placebo. All patients received 0.15 mgm./kgm. of morphine intramuscularly every 4 hours. Forty four patients received indomethacin, while 46 received placebo. The patients were asked to provide a subjective score of their pain. In addition, the total number of morphine doses and the duration of parenteral analgesic requirement were recorded. Finally, pulmonary function of the patients in the two groups was measured.
The postoperative pain scores were significantly better in the group of patients receiving indomethacin, even though this group received significantly fewer doses of morphine. The duration of parenteral narcotics accounted for the much lower number of morphine doses in the treatment group as opposed to the placebo group, 29 hours versus 55 hours. Pulmonary function was not significantly different except for a lower $pCO_2$ in the group of patients receiving indomethacin.

Enthusiasm was dampened slightly by a higher incidence of bleeding among those who received indomethacin. None of these bleeding problems were particularly troublesome, but the number was significant p=0.O5.
**Ronald C. Merrell**

**Vaginal Colonization with Group B Beta-Hemolytic Streptococcus as a Risk Factor for Post-Cesarean Section Febrile Morbidity. Howard L. Minkoff, Marcelino F. Sierra, George F. Pringle and Richard H. Schwarz. Am. J. Obstet. Gynecol., 1982, 142: 992-995.**
THIS RELATiONSHIP between colonization of the vagina with group B beta-hemolytic streptococcus and postcesarean febrile morbidity was investigated prospectively. Ninety-two patients seen during a four month period were involved in the study. Vaginal cultures of all patients were taken upon admission. Eighteen of the 92 patients had vaginal colonization with group B streptococcus.
Patients with colonization had a significantly higher incidence of premature rupture of the membranes, although no difference was found between the duration of ruptured membranes. All parameters of postcesarean morbidity were increased among patients with colonization. For example, 67.0 per cent of those with colonization and 30.0 per cent of those without colonization had standard fever develop, while 61.0 per cent of those with colonization and 12.5 per cent of those without were diagnosed as having endometritis. Sixty-one per cent of those with colonization and 26.0 per cent of those without received antibiotics. Among patients with standard fever, 16.6 per cent of those with colonization and 8.0 per cent of those without had blood cultures which were positive for group B streptococcus. Group B streptococcus was recovered postoperatively from urine, endometrium, blood or a combination of

sites in 58.3 per cent of those patients who had colonization and standard fever. Anaerobes or gram-negative aerobes were the predominant organisms cultured from patients who did not have colonization. Although the study population was small, the results of this study indicate an increase in postcesarean febrile morbidity in patients who have colonization with group B beta-hemolytic streptococcus

**Judith S. de Nuno**

**Progress and Orientation of Chemotherapy for Carcinoma of the Uterine Cervix (Progres et Orientations de la chirniotherapie des cancers du col uterin). J. Chauvergne, J. Pigneux, A. Avril and B. Hoerni. Rev. Fr. Gynecol. Obstel., 1982, 77: 233-238.**

IN THIS ARTICLE, it is stated that carcinoma of the uterine cervix has a good prognosis when treatment is begun betore extension arni that epidermoid carcinoma of the uterine cervix is chemosensitive. The reported chemoresistance of epithelial carcinoma is neither constant nor insurmountable.

The classic methods of therapy are reviewed. Cisplatin has been added to the regimen and, by itself, produces objective responses in 40 per cent of patients; thus, it is the primary medication for epidermoid carcinoma. It is an important additive to the arsenal of medications for the treatment of carcinoma of the uterine cervix. It provides local treatment as well as prevention of secondary growth. Thus, the introduction of chemotherapy before radiation may prevent dissemination of disease. Eight of ten times, it was the local sterilization that was not obtained in 40 to 60 per cent of treated patients. It is emphasized that finding the most effective treatment to eradicate the tumor is imperative. Radiotherapeutic techniques have reached the limits of their possibilities. Inauguration of chemotherapy will cooperate with the cytolytic effect of irradiation by simple reduction in the size of the tumor and wifi prolong the therapeutic effect. The use of methotrexate and Adriamycin, doxoroubicin, will affect the oxygenation of the tumor tissue. The risks of dissemination justify the early use of a chemotherapeutic regimen that has proved effective for other tumors. Clinical trials will be necessary to determine the efficacy of chemotherapy in the treatment of carcinoma of the uterine cervix.

**Paul D. Urnes**

**Adjuvant Chemotherapy in Advanced Head and Neck Cancer, an Update. Monica B. Spaulding, Anjum Khan, Rafael De Los Santos and others. AmJ. Surg., 1982, 144: 432-436.**

FORTY-EIGHT PATIENTS with advanced squamous cell carcinoma of the head and neck at Stage and IV were treated with 80 mgm/$m^2$of cisplatin followed by hydration and mannitol, and on the second day, 1.4 mgm/$m^2$ of vincristine was administered intravenously and after 6 hours, 15 mgm./$m^2$ was administered by continuous infusion for five days. Combination chemotherapy was repeated after 21 days. Forty-three patients underwent surgical treatment after two to 14 days. Block dissection of the neck was performed upon all of these patients. Only four patients underwent radiotherapy after operation.

Partial or complete tumor regression occurred in 88 per cent of the patients. Eleven of these patients had complete remission, five of whom were normal microscopically. Cisplatm caused mild, reversible renal insufficiency in nine patients. Myalgia and fever occurred frequently while bleomycin was administered. Only one patient had marrow depression develop. Twelve patients had recurrence of tumor within 18 months after operation. The median follow-up period was 27 months. No other patients had recurrences. It is concluded that preoperative chemotherapy was a benefit for patients with locally advanced carcinoma of the head and neck.

**John A. McCredit**

**Cyclosporin A as Sole Immunosuppressive Agent in Recipients of Kidney Allografts from Cadaver Donors. Preliminary Results of a European Multicentre Trial. Lancet, 1982, 2: 5 7-60.**

IN THIS PRELIMINARY TRIAL, eight centers from Europe joined to take part in exhibiting cyclosporin A as a sole immunosuppressant in patients receiving cadaveric renal allografts. One hundred and seventeen patients were given cyclosporin A, and the control group of 115 patients was given azothiaprine and steroids, and the results were compared.

The preliminary data are interpreted with caution. Both patient and graft survival rates are better with cyclosporin A than with azothiaprine and steroids. At the end of the follow-up period of 11 months, renal graft survival probability estimates were 73 per cent for those receiving cyclosporin A, as compared with 53 per cent for those in the control group. Two of the patients who received cyclosporin A died, and seven control patients died. Eighty-two per cent of those who received cyclosporin A received cyclosporin A only, while 17 per cent changed to azothiaprine and steroids, and one patient received prednisolone in addition; 27 per cent of the 117 who were given cyclosporin A never received steroids.

Renal function after six months is similar among patients in both groups-notwithstanding nephrotoxicity and hepatotoxicity of cyclosporin A with its additional advantage of avoiding dangers of the development of diabetes, hypertension hyperadrenocorticism, hemorrhage of the gastrointestinal tract and probably malignant conditions, including lymphoma. In this study, a note of cautious optimism is found for the use of cyclosporin A for the control of rejection in patients with cadaveric renal allografts.

**R. D. Sheth**