Selected Abstracts

Surgical Treatment of Retroperitoneal Fibrosis with Omentoplasty. MARCO CARINI, CESARE SELL! MICHELANGELO RIZZO and others.Surgery, 1982, 91: 137-141.
TO DATE, The pathogenesis of idiopathic retroperitoneal fibrosis is not well defined, and its treatment is mainly palliative and is aimed at resolving obstructive complications. The disease is usually localized in a middle retroperitoneal area and compresses the local structures, particularly the ureters and the inferior vena cava, presenting an unforeseeable evolution.
The goal of surgical procedures for retroperitoneal fibrosis is to free the ureiers from sclerotic tissue and preserve the issue from further extension of the disease. The omentum may be used as an efficient barrier against the recurrence of fibrosis. Eleven patients with idiopathic retroperitoneal fibrosis treated with ureterolysis and omentoplasty are presented. Upon four patients, the procedure was performed bilaterally, and upon seven, the omentum was used to protect only one ureter, but in six, there was a surgical or functional solitary kidney. Of 15 ureters, residual dilation was observed in only two, and marked clinical improvement was observed in all patients. The mean follow-up period was 51 months.
-E. Theodore Palm.

Peritoneo-Venous Shunts for Malignant Ascites. Ian R. Gough. Aust. N.Z.J. Surg., 182, 52: 47-49.
ELEVEN Le Veen peritoneovenous shunts were placed in ten patients who had proved malignant ascites which was uncontrolled despite previous treatment. All of the patients had been treated with diuretics and repeated paracentesis: Eight had previous intraperitoneal cytotoxic agents instilled. None had infected or heavily bloodstained ascites. The sites of primary malignant disease were the gastrointestinal tract, three patients; the kidney three; the breast, two, and the ovares, two. The ages of the patents, six women and four men, ranged from 43 to 73 years.
The shunts were placed in position with eight patients under local anesthesia and sedation and with two under general anesthesia. The perforated limb was placed in the peritoneal cavity through an incision of the upper part of the abdomen and secured with a purse-string suture. The rigid valve housing was placed between the posterior rectus sheath and rectus abdominis muscle, and the venous limb was tunneled subcutaneously along the anterior chest wall to a second incision in the neck. The venous limb was then cut to an appropriate length, inserted into the external jugular vein and advanced so that its tip was in the superior vena cava.
Complications were shunt blockage in three patients at 12, six and four weeks, respectively, infection of the abdominal wound of one patient and edema of the ipsilateral arm for one week in a patient who had the shunt inserted through the subclavian vein. There was no evidence of acceleration of the malignant condition following shunting. There was no clinical or laboratory evidence of disseminated intravascular coagulation.
The shunts functioned and controlled ascites for up to 15 months in five of seven patients until death occurred as a result of the underlying malignant disease. In two of three surviving patients, a shunt has controlled ascites for six and seven months respectively; in the third patient, a shunt blocked after three months and was replaced by another shunt which is still functioning after six months. A peritoneovenous shunt is indicated for patients who are likely to survive more than one month and whose ascites is not controlled by more conservative measures.
- You-Sah Kim.

Postoperative ileus; Clinical Observations and Results of a Questionnaire to Members ol the Royal Belgian Surgical Society (Ileus postoperatoire. Observations ciniques et enquete aupres des

membres de la Societe Royale Beige de Chirurgie) A. BREMER. Acta Chir. Beig., 1982, 82: 73-84.
THE FIRST PART of this study concerned a prospective clinical study of 71 patients having minor surgical procedures of the abdominal wali or laparotomy. In the entire group, intestinal sounds were present after 1.3 days, flatus was passed after 2.3 days, and the first light meal. was given to the patient at 2.5 days. After minor operations, abdominal sounds were first noted after 1.1 days, flatus was passed after 1.9 days, and the first meal was given after 1.2 days. After laparotomy, intestinal sounds were noted after 1.9days, passing of flatus was noted after 3.0 days, and feeding was noted after 4.5 days. On the first day postoperatively, intestinal sounds were present in 26 per cent of the patients following extensive operations and in 82 per cent following less extensive operations.
Forty-five members of the Belgian Royal Society of Surgery responded to a questionnaire concerning their personal experience with ileus involving 196 patients after total gastrectomy and 55 patients after total colectomy. Postoperative ilcus following these two types of operation appears to be of the same magnitude as that which followed operations of the laparotomy group in the preceding study. Because ileus occurred in patients who had total colectomy, it is concluded that the small intestine participates in the process of ileus.
-Frederick W Preston.

Definitive Surgical Therapy for Incapacitating-"Gas-Bloat" Syndrome. M.P. HOCKING, J.W.MAHEF and E.R. WOODWARD. Am. Surg., 1982,48: 131 - 133.
ThE GAS-BLOAT SYNDROME, a reflection of the valvuloplastic effect of Nissen fundoplication, occurs in 17 to 26 per cent of the patients who undergo this procedure. Occasionally, patients will experience incapacitating symptoms of epigastric discomfort, weight loss and excessive borborygmi and flatulence.
Four such patients were treated by a take-down of the fundoplication and construction of a posterior gastropexy of Hill. All of the patients were relieved of gas-bloat symptoms. Three patients were observed for one to three years, and the fourth patient was observed for two months. Since three patients had a history of chronic obstruction of the small intestine, it was postulated that, in patients with Nissen fundoplication, obstruction of the small intestine may interfere with the ability of the gastrointestinal tract to compensate for the increase in gastric air.
-Clayton H. ShaMey.

Surgical Treatment of Ulcerative colitis In children. ROBERT L. TELANDER, STEPHEN L. SMITH, HELENKA M. MARCINEI(and othersSurgery, 1981,90: 787-794.
ThE 20 YEARS EXPERIENCE of the authors• with the treatment of ulcerative colitis in children from 1960 to 1979 is reviewed. The records of 100 children who ranged from two to 19 years of age were reviewed retrospectively. There were 52 females and 48 males. The most common signs and symptoms were bloody diarrhea, 88 per cent of the patients;. nonbloody diarrhea, 9 per cent; abdominal pain, 74 per cent; anemia, 74 per cent; weight loss, 62 per cent; protein deficiency, 60 per cent, and extracolonic manifestations, 26 per cent. The time of onset of symptoms to diagnosis ranged from immediate to 12 years, with a mean of 1.1 years. The diagnosis was made by sigmoidoscopy in 85 per cent of the patients, barium enema in 86 per cent, and rectal biopsy in 16 per cent. Seventy-nine per cent of patients had pancolitis.
Medical therapy included a combination of. azulfidine, oral steroids and steroid enemas. The time from diagnosis to the operation ranged from immediate to 14 years with a mean of 2.2 years. Thirteen of the 100 surgical procedures were performód on an emergency basis for severe bleeding, toxic megacolon and perforation. A variety of initial operative procedures was performed, including total protocolectomy with Brooke's ileostomy in 59 per cent of the patients colectomy with rectal mucosectomy and ileoanal anastomosis in 9 per cent, subtotal colectomy and ileorectostomy in 9 per cent, proctocolectomy with a Kock pouch in 8 per cent and miscellaneous subtotal colectomies with

retained rectum in 15 per cent The over-all rate of reoperation was 36 per cent. Indications for reoperation included obstruction of the intestine in 9 per cent of the patients, complications of the stoma in 8 per cent, completion proctectomy in 10 per cent, excision of the perineal sinus in 4 per cent and drainage of the abscess in 2 per cent.

Seven patients in this series died. Five patients died in the immediate postoperative period as a result of sepsis. One patient died of cardiac failure, and one patient died of cancer. The operative mortality in instances of emçrgency was 23 per cent, three of 13 patients. In elective instances, the operative mortality was 2.3 per cent, two of 87 patients.

Long term follow-up data on 95 per cent of the patients who are still alive are given in detail. Fifty-nine per cent of patients with Brooke's ileostomies were well satisfied and 38 per cent were moderately well satisfied with their results at follow-up study. A 90 per cent satisfaction rate was obtained in patients who had either a Kock pouch or ileoanal anastomosis. It was pointed out that ileorectal anastomosis in nine patients was rather unsatisfactory, since only two of these patients continued to have a satisfactory result.

Failure of growth was an indication for proceeding with operation in 14 per cent of these patients. There was an increase in the height percentile in 84 per cent of the patients after operation, with the median height percentile for the entire group increasing from the 39th to the 57th percentile. It was emphasized that growth retardation is an important indication for operation and that, when it is the primary indication, it should be performed before epiphyseal closure. Ninety-six per cent of the patients in this series reported that general health at follow-up study was good to excellent and that they had only minimal limitations in their activities. The discussion was concluded with the statement that a surgical procedure not only eradicates the ravages of the disease, as evidenced by the follow-up results, but also eliminates the potential for cancer and the time consuming and costly visits that are necessary for patients who have not undergone operation.

-Scott Norwood