Selected Abstracts

SELECTED ABSTRACTS FROM SURGERY GYNECOLOGY AND OBSTETRICS

The Malignant "Cold" Nodule of the Thyroid. Alfred D. Katz and Warren J. Zager. Am. J. Surg., 1976, 132:459.

Much has been written about the therapy for carcinoma of the thyroid and the clinical solitary thyroid nodule. The increased frequency of papillary carcinoma of the thyroid has been reported, yet the prognosis continues to improve. With the varieties of opinion concerning therapy for nonfunctioning thyroid nodules differing geographically and locally, an experience with patients operated upon for cold nodules of the thyroid is reviewed.

A series of 910 patients included 714 females, 78.5 per cent, and 196 males, 21.5 per cent. Of the 910 patients, 202, 22.2 per cent, had malignant tumors. The papillaryfollicular grouping comprised 88 per cent, 178, of the total group.

In reviewing the literature on carcinoma of the thyroid and the clinically solitary cold thyroid nodule, one encounters widely divergent opinions concerning the incidence and treatment of this malignant disease. In analyzing the data from 910 patients, the high incidence rates of malignant growth of cold nodules in patients in the third decade, 29.6 per cent, and older than 70 years, 40.4 per cent, were the most startling. From these data of patients older than 70 years and the findings of some long-standing papillary carcinomas becoming anaplastic carcinomas if left untreated, surgical treatment for the cold nodule in the elderly is suggested as unhesitatingly, or even more so, than in the younger age groups.

The prognosis of carcinoma of the thyroid, whether occult or in a nodule, but without clinical evidence of metastases, is quite favourable: 178 patients with carcinoma of the thyroid, 88 per cent, had tumors in the papillary-follicular grouping and most were without metastases. Those who die of carcinoma usually present initially with far advanced diseases.

When clinically solitary cold nodule is culled from the nodular goiter and functioning nodules and when ultrasonic evaluation shows the nodule to be solid, surgical treatment is strongly indicated. The oldest age group with the highest incidence of malignant tumors should be specially watched and considered for operation.

Donald M. Clough

Surgical Treatment of Cancer of the Thyroid. Al. Damian, E. Angelescu, D. Stoenescu and A. Oproiu. Acta Chir. Belg., 1975, 74:474.

Seven hundred and sixty instances of cancer of the thyroid with emphasis on different aspects of the exact role of surgical treatment are described. It was found that 9.5 per cent of patients operated upon for disease of the thyroid had cancer. Females outnumbered males in a ratio of three to one. Age varied from five to 85 years with a peak incidence between 40 to 50 years.

Cancer of the thyroid used to be more common in areas of endemic goiter, but with increased goiter prophylaxis this is now not so. Eighty-two per cent of the patients were normothyroid, 15 per cent were hypothyroid and only 3 per cent were hyperthyroid. Progression of the disease was slow in 62 per cent and accelerated in 38 per cent. Local extension was frequently seen 10 per cent to muscle, 9 per cent to the larynx, 3.4 per cent to the esophagus and 2.3 per cent to the wall of the chest. Early diagnosis is important; 62.3 per cent of the instances were diagnosed clinically, 30 per cent by frozen section and 7.7 per cent by lymph node biopsy.

Operative indications differ according to the stage of the disease. The TNM international classification of staging was used. Stage I-no palpable tumor, small cold nodule or carcinoma in situ—was treated with total thyroidectomy followed by radioactive iodine therapy. Stage II-multiple tumors or one large tumor deforming the gland with unilateral or bilateral mobile nodes and no distant metastases—was treated with total thyroidectomy and bilateral lymph node dissection followed by therapy with radioactive iodine and thyroxine. Stage III-extensive fixed tumor with fixed unilateral or bilateral nodes and distant metastases-was treated with total thyroidectomy, unless technically impossible, followed by radioactive iodine therapy for encapsulated tumors or cobalt therapy for nonencapsulated tumors and thyroxine. Well differentiated forms were seen in 448 instances and undifferentiated forms in 312.

The basis for postoperative therapy depends on the histology of the tumor, endocrine function and the method of growth. Surgical intervention tends to stimulate existing metastases, particularly in follicular carcinoma, because of hypophyseal release of thyrotropin. In this way, the metastases became susceptible to radio-active iodine therapy.

In this series there were 211 instances of metastases to regional lymph nodes, twenty-one showed skeletal spread and 19 spread to viscera. Postoperative hormone treatment is mandatory.

It inhibits the pituitary hypophysis and also prevents postoperative myxedema.

Long term complications included 49 local recurrences, 74 lymph node recurrences, 25 tracheostomies structures. There were also 155 unilateral and 12 bilateral recurrent laryngeal nerve palsies, 32 instances of transient tetany and one of permanent tetany. At the present time, total thyroidectomy followed by radioactive iodine or cobalt therapy and thyroxine is recommended as the best treatment.

Petru A. Petrila

Management of Uremic Pericarditis; a Report of 11 Pakistanis with Cardiac Tamponade and a Review of the Literature. J.E. Morine, D. Hollomby, A. Gonda and others. Ann. Thorac. Surg., 1976, 22:588.

Even with what is considered adequate hemodialysis therapy in patients with uremia, there is still a 10 to 17 per cent incidence of pericarditis. The management of 11 patients with uremia in whom pericarditis developed while they were undergoing renal dialysis is reviewed.

Six patients required pericardicentesis but this did not prove to be definitive therapy. Two patients died of cardiac arrest during and immediately after a pericardial tap. Anterolateral pericardiectomy through a left thoracotomy was performed in nine patients and there were no surgical deaths. There have been no recurrent effusions and no instances of constriction in a maximum follow-up period of five years.

These findings reaffirm the observations of others that patients undergoing dialysis tolerate operation surprisingly well. In comparison with other measures such as intensified dialysis or corticosteroids, early surgical drainage appears to be a safe and reliable approach to the problem of uremic pericarditis.

Frank J. Milloy

Diagnosis of Primary Retroperitoneal Tumors. Ralph E. Duncan and Arthur T. Evans. J. Urol., 1977, 117:19.

An analysis of 27 patients with primary retroperitoneal tumors and a review of the literature are presented. Primary retroperitoneal tumors must be included in the differential diagnosis of any abdominal mass. Sarcoma is the most common histopathologic type. A painful abdominal mass is the most characteristic presentation followed by weight loss, weakness, back pain, nausea and vomiting. Twenty-one of these patients presented with an abdominal mass, six with tenderness, six with abdominal protuberance and five with hepatomegaly.

Laboratory data are nonspecific. Laparotomy and biopsy of the mass have been the only reliable methods to diagnose definitively a retroperitoneal tumor.

Plain roentgenograms of the abdomen demonstrated abnormalities related to the tumor in 12 of the patients. Roentgenograms of the chest indicated the presence of tumor in 13 of the patients. The intravenous pyelogram and retrograde pyelogram revealed displacement of the kidneys or ureters in 85 per cent of the patients who had these studies. Barium contrast studies of the gastrointestinal tract demonstrated abnormalities in 45 per cent of barium enemas and 66 per cent of barium meals. Abdominal angiography was performed in six patients, and four of this group benefited from the procedure. Extra-peritoneal pneumography is limited to the evaluation of confusing pararenal masses.

Twelve patients had excision for cure or palliation, six of these had resection considered complete by the surgeon. Recurrence developed in four of these. Radiotherapy is the treatment of choice for lymphomas. Chemotherapy has proved beneficial in the treatment of lymphoma. Multiple incomplete excisions may be necessary and should be considered acceptable because of the low biologic potential many of these tumors demonstrate.

Gordon L. Kauffman

Ambulatory Treatment of Perirectal Abscesses. K.J. Gorze and T. Mohr. Dtsch. Med. Wochenschr., 1976, 101:1450.

Over a five year period, 237 ambulatory patients with anorectal abscesses were treated. A circular incision was used, generally excising inflamed skin and subcutaneous tissue. Attempts were made to locate fistulas and inflamed crypts, but sphincterotomy was avoided. Of organisms retrieved, coliforms and Staphylococcus aureus predominated.

With complete follow-up study, there were 29 recurrences and 34 fistulas. Disturbance of sphincteric control rarely resulted.

Abscess and fistula are two stages of the same inflammatory process. Why a fistula does not follow all perirectal abscesses is unclear. The abscesses are here categorized as high intermuscular, deep intermuscular, perianal and ischiorectal. The former two are believed to lead most often to fistula formation. Even in such instances, adequate and prolonged drainage should prevent many instances of fistula formation.

Frank J. Scarpa

Usefulness of Gastric Analysis in Peptic Ulcer Disease; a Study of 410 Patients After Histalog Stimulation. A. Connet and G. Terris. Sem. Hop. Paris, 1976, 52:1981.

Gastric Analysis after maximal stimulation with Histalog (betazole) was performed in 410 patients. A basal rate of acid production was measured as was the rate after stimulation. A peak rate of acid production was established. There were 325 men, 74 per cent, and 85 women, 26 per cent. A control group consisted of 60 persons with no gastrointestinal disease. Two hundred patients had roentgenologic evidence of duodenal ulcers, 60 patients had clinical symptoms compatible with duodenal ulcers but no firm roentgenographic documentation, 38 patients had gastric ulcers and 52 patients had vague dyspeptic symptoms.

The control group had a small nondiagnostic elevation of acid production. The patients with duodenal ulcers had a significant increase in acid production during the test period. This rise in the rate of acid secretion was more constant in men than in women. This elevation of the acid secretory rate was also present in those patients with symptoms of duodenal ulcer. The patients with gastric ulcers and those with dyspeptic symptoms had widely dispersed and nondiagnostic responses to the Histalog stimulation.

The rate of acid secretion after Histalog stimulation is a valuable adjunct in the diagnosis of duodenal ulcers in patients in whom the roentgenologic evidence is not clear..

Roland S. Philip