Selected Abstracts

SELECTED ABSTRACTS FROM SURGERY GYNECOLOGY OBSTETRICS

Abdominal-Wall Tenderness; a Useful Sign in the Acute Abdomen. Hamish Thomson and D.M.A. Francis. Lancet, 1977, 2:1053.

Pain on abdominal palpation may, in any one place, arise from three different structures; the abdominal wall, the partietal peritoneum and the underlying viscus. To differentiate the first from the second two requires merely the tensing of them logically, since the partietal peritoneum and the abdominal viscera are protected, it must be arising from the abdominal wall itself. This simple test may not be new but is certainly neglected in textbooks of clinical surgery. An account of an experience with this test as used on 120 patients admitted as emergencies with abdominal pain is presented. Twenty-four of these 120 patients had a positive test, but one of these had a detectable intra-abdominal cause. In the remaining 23, no reason for the pain could be found.

The abdominal wall tenderness test is quickly and easily done and the result is usually gratifyingly unequivocal. The condition responsible, however, is a mystery. Muscular strain is a posisibility, but only three of the patients gave a suggestive history. The test has important limitations. First, it should not be used in children or the elderly because of the danger of misinterpretation. Second, it is useless and entirely inappropriate in patients with generalized abdominal pain and rigidity. Third, in the presence of an intra-abdominal abscess it is theoretically dangerous.

The proper use of the test, in fact, is not in patients with a clear cut surgical condition but in those who may or may not need a laparotomy. It should be interpreted only in the context of all the clinical signs and symptoms with reexamination at intervals when necessary.

Abdominal wall tenderness accounts for a substantial proportion of surgical emergency admissions, and an atypical history coupled with apparently great local tenderness can pose an anxious diagnostic problem. In such instances a positive abdominal wall tenderness test has been found to be a reliable indication of innocent abdominal contents.

Donald M. Clough

Operative Treatment of Duodenal Ulcer. M. Rothmud, W. Stowe and F. Kummerle. Dtsch. Med. Wochenschr., 1977, 102:1409.

A survey was made of surgeons as to what their favorite operations were for duodenal ulcer; 428 answers were received for 670 queries. The investigators were surprised to find that for uncomplicated duodenal ulcer, 53 per cent of the surgeons preferred resection, usually Billroth II, over vagotomy. Nine per cent did vagotomies and 2 per cent did a combined resection and vagotomy. One of 100 surgeons did truncal vagotomy. Five per cent did selective vagotomy. Selective proximal vagotomy with or without a drainage procedure was considered the method of choice by 15 per cent.

In bleeding duodenal ulcer, 76 per cent of the surgeons favoured resection; 12 per cent combined resection with vagotomy. Seventeen per cent combined vagotomy with simple oversewing of the bleeding point. With gastric outlet stenosis and posterior penetrating ulcer, 80 per cent of the operators preferred resection. In free perforation of a duodenal ulcer up to eight hours postperforation, 27 per cent of the surgeons did a resection. One-half did simple closure; 7 per cent did oversewing plus vagotomy.

Surgeons who completed their training before 1947 preferred resections; diplomates since 1953 and later preferred vagotomy. University surgeons, 68 per cent, leaned toward vagotomy for all patients with duodenal ulcer; only 34 per cent of non-university surgeons did.

Although in the English-speaking countries, most surgeons now favour some sort of vagotomy and drainage procedure for both simple and complicated duodenal ulcer and many published

series have shown good results and low mortality, this procedure has not yet made much impact in West Germany, particularly among older surgeons in the municipal and township hospitals away from the universities. Every surgeon active in doing operations on the stomach should strive to become equally familiar with resection and vagotomy procedures. University surgical clinics should make refresher courses and training sessions available to show outlying surgeons the latest vagotomy techniques.

Willian B. Gallagher

Emergency Colectomy for Inflammatory Bowel Disease. George E. Block, A. R. Moossa, David Simonowitz and Shakeela Z. Hassan. Surgery, 1977, 82:531.

The records of 53 patients who underwent colectomy as an emergency procedure for complications of inflammatory disease of the intestines were reviewed. The operative indications were hemorrhage in 23, toxic megacolon in 23, free perforation in the three and medically uncontrollable fulminant disease in four. In approximately one-half of the patients, a precise diagnosis as to type of disease could not be made preoperatively. The subsequent diagnoses were ulcerative colitis, 39; Crohn's disease, 13, and pseudomembranous colitis, one. All 35 patients who underwent examination by proctoscopy had evidence of disease.

Four deaths occurred in 39 patients who underwent abdominal colectomy, ileostomy and mucous fistula. Four of the 16 patients who underwent colectomy for hemorrhage had severe rectal hemorrhage in the postoperative period. Twenty-six patients underwent subsequent protectomy and three had an ileorectal anastomosis.

One death occurred, in 14 patients who underwent one stage proctocolectomy. Eleven of these 14 patients had postoperative complications, compared with 23 of 39 patients treated by abdominal colectomy. The merits of various emergency surgical procedures in the management of inflammatory disease of the intestines are discussed.

Robert S. Rhodes

Acute Cholecystitis; 137 Patients Studied by Infusion Tomography of the Gallbladder. Rogelio Moncada, Manuel Cardoso, Robert Danley and others. Am. J. Roentgenol., 1977, 129:583.

While conventional oral cholecystography and intravenous cholangiography depend on opacification of the lumens of the gallbladder or biliary tree, the recently introduced infusion tomography of the gallbladder allows direct evaluation of the wall of the gallbladder. A retrospective study of 137 patients who underwent infusion tomography of the gallbladder and subsequently had a cholecystectomy for cholecystitis was presented.

The diagnostic accuracy for acute cholecystitis was 96 per cent in abnormal instances and 94 per cent in normal instances. The procedure took less than 30 minutes. No complication was presented; the morality and morbidity described were the same as with intravenous urography. It was shown to be an accurate, rapid and safe diagnostic aid in the evaluation of acute cholecystitis. However, in chronic cholecystitis, the false-negative rate of infusion tomography of the gallbladder was so high that it was not recommended as a diagnostic test.

Stephen C.K. Lau