SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 80 To 81

Fatema Jawad (Sughra Bai Millwala Hospital, Karachi.)

Nineteen patients who underwent extensive head and neck surgery for removal of cancer had repair surgery with a pectoralis major flap. There were 12 males and 7 females with the mean age being 48 years. The lesions were state-Ill or IV tumours of paranasal sinuses, maxilla, mandible, oral cavity, tongue and laryngopharynx. The surgery performed was en-bloc radical máxillec tomy, resection of maxila and one half of mandible with block neck dissection, exenteration of the orbit, maxillectomy and block dissection, sub-total mandibulectomy with block dissection, total glossectomy, total laryngectomy and bilateral block dissection and laryngopharyngectomy.

The pectoralis major muscle was used for reconstructive surgery. It was removed along with the overlying skin in the shape required to fill the gap, and leaving the minor muscle behind. A tunnel was developed in the neck preserving a bridge of the cervical skin. The muscle flap along with its blood vessels was pulled through this tunnel into the neck to repair the defect.

Minor post operative complications were encountered as sub-total necrosis, wound dehiscence, partial breakdown, limited degree of shoulder and arm disabffity and one case of marked chest wall deformity. Undesirable effects of the radical surgery were had as aspiration pneumonia, deep vein thrombosis and pharyngeal fistulae. All responded to treatment. One patient died due to severe pulmonary and wound infection. In long term follow up there was one case of distant secondaries, one of local recurrence and 15 were alive and well.

The pectoralis major mycocutaneous flap for reconstructive surgery in head and neck defects had been found to be strong and reliable. It is a single stage procedure, re-surfaces large gaps and leaves no visible scars. It is a definite choice for intra-oral reconstruction.

Tuberculous Ascites Presenting as Umbilical Hernia, A Report of 3 Cases.
Bokhari, H.
Pakistan Journal of Surgery, 1981; 1: 69 - 70.

Three cases of umbilical hernia due to tuberculous ascites have been described. A 25 year old lady presented with a reducible umbilical hernia. It was felt to contain a part of the gut. Her blood picture and chest X-ray were normal. Surgery was done under general anaesthesia. On opening the sac, straw coloured fluid was found with tubercies on the peritoneum and small gut. Repair was done by the Mayo's technique using silk. Histological examination of the sac confirmed tuberculosis and anti-tubercular therapy gave complete relief in one year.

The other two cases, both females aged 22 and 19 years also presented with reducible umbilical hernias and small amount of ascites. A clinical diagnosis of abdominal tuberculosis was made and anti-tubercular treatment was started. After a month of therapy the size of the hernia reduced and in 3 months time it disappeared completely.

Umbilical hernia is seen in adults usually in multiparous females where it is thin walled and reducible. In males it is encountered in very obese people where it is irregular, firm and thick walled. It is not easily reducible and contains omentum. When ascites is co-existant with umbilical herniae in our country, it is usually due to abdominal tuberculosis as this disease has a high incidence. In such cases surgery is unnecessary and anti-tubercular therapy provides complete relief.

Pseudopancreatic cyst in Children and its Management 5 years experience at National Institute of Child Health,JPMC., Karachi.
Aziz,A.,Mirza,F.
Pakistan Journal of Surgery, 1985; 1: 71 -73.

Seven children between the ages of 4 and 12 years underwent surgery for pseudopancreatic cyst at the N.I.C.H. Karachi during the period 1980-1984. Five of the patients had a history of blunt abdominal trauma resulting due to a road traffic accident or fall from a height or a blow on the abdomen during a fight. Of the remaining two, one had a history of mumps and the other had a febrile illness associated with abdominal pain and vomiting.

The presenting complaints were an abdominal mass followed by pain, nausea, loss of appetite and loss of weight. Diagnosis was based on the history, clinical examination, radiological and ultrasonographic investigations.

Exploratory laparotomy was performed in all the cases. Four of them had a cyst in the body of the pancreas, two in the head and one in the tail. Cystogastrostomy was done in 5 cases and external drainage in two of them. Post-operative recovery was uneventful and no complications were recorded in the follow up period of one year.

A pseudopancreatic cyst lacks an epithelial lining and follows the path of least resistance usually ebbing retrogastric. It is formed secondary to trauma and sometimes follows pancreatic inflammation. Diagnosis is confirmed by ultrasonography, the accuracy of which is 90 percent. Management is operative but in some cases a ponservative treatment may lead to a spontaneous resolution of the cyst. From the surgical procedures, external drainage is done for immature cysts and internal drainage with procedures as cystogastrostomy, cystoduodenostomy and cystojejunostomy are used in the other cases.

Primary Carcinoma of the Nasal Septum Bititci, 0.0.,
Yuksel, A.H.
Pakistan Journal of Otolaryngology, 1985; 1: 144-147.

A case of squamous cell carcinoma of the nasal septum' in a 55 years old female is described. The presenting symptoms were dryness and itching due to crust formation in the right side of the nose. A gradually enlarging tumour was then noted inside the nose. This growth was solid and bled on touch. The anterior septum was deviated to the right. There was some atrophy of the nasal mucosa and enlargement of the nasal cavities. On the right side of the septum a growth of 5mm diameter was seen anteriorly. It was covered with normal looking mucosa, but bled on touch. It occupied the Littles area. The surrounding mucosa was atrophic and on the opposite side septum there was a soft infiltrative thickening of the mucosa. A punch biopsy of the tumour was taken and the histopathology examination revealed a squamous cell carcinoma. There was no regional or distal lymph node involvement.

Surgery was performed under local anaesthesia and the tumour was excised with the surrounding healthy tissue. After complete healing radiotherapy with co-60-tele was carried out to prevent spread. The covering epithelium was of the stratified squamous type below which was the tumour tissue which had infiltrated the cartilage medially. The tumour cells contained large hyper-chromatic nuclei and abundant cytoplasm.

Though primary carcinoma of the nasal septum is rare, its diagnosis is simple and can be made only by a proper examination. The prognosis of carcinoma in situ is good and in early cases surgical excision is satisfactory. In progressive cases radiation and surgery is indicated. In tumours involving the margin of the dermis of vestibulum nasi and nasal septal mucosa, external radiotherapy and radium implantation gives a better response. Cases with metastasis in the neck require radical dissection but the results are not successful.