

## Selected Abstracts

Pages with reference to book, From 26 To 27

### **A Comparison of Gastric Bypass and Gastroplasty for Morbid Obesity. Joel B. Freeman and Heather J. Burchett. Surgery, 1980, 88:433.**

FIFTEEN gastric bypass procedures and then 15 gastroplasty operations were performed upon selected patients with morbid obesity. Following that, the next 48 patients were treated with gastroplasty operations and the results of this report are detailed. The six month follow-up examination of the first two groups showed comparable weight loss and, therefore, the gastroplasty procedure was selected for the remaining 48 patients. The authors found that gastroplasty, although a simpler and probably safer operation, does have a significant mortality and morbidity. It was emphasized that careful selection and close long term patient follow-up examination are necessary for successful results.

**-C. Andrew Heiskeil**

### **Malignant Degeneration of Benign Ulcers; Evaluation of Frequency On Routine Endoscopy. (Degenerescence maligne sur ulcere benin; Evaluation de sa frequence en endoscopie de routine).**

**L. Bekri, M. L. Nicholas, J. Haot and P. Mainguet. Acta Gastroenterol. Belg., 1979, 42:450.**

THE PROBLEM OF malignant degeneration of benign gastric ulcers is as yet unresolved. The few prospective endoscopic studies report an incidence of approximately 1 per cent in patients examined. From 1975 to 1978, detailed morphologic and histologic examination of specimens taken at biopsy were done on 3,365 routine endoscopies. The lesions were examined systematically, photographed and at least ten biopsies obtained from all quadrants. Of 308 gastric ulcerations examined, 86 or 28 per cent showed lymphoma, 74 or 24 per cent had invasive adenocarcinoma, nine or 2.9 per cent showed early cancer and three or one per cent had ulcerocancer. Two criteria were used for this last diagnosis; chronicity of the ulcer as shown by complete rupture of the fibers of the muscular coat with fusion of this layer with the muscularis mucosa and the presence of carcinomatous erosions of the borders of the ulcer without infiltration of the base.

Of the three patients falling into the category of ulcero-cancers, two had benign ulcers with focal areas of carcinomatous change on the margins and the third was a large neoplasm on the margin of a huge crateriform benign ulcer that had been present for at least 10 years. The authors do not feel justified in concluding that these cancers resulted from the ulceration since their study was retrospective.

Superficial carcinomas of the stomach are slowly progressive and can exist concurrently with benign ulcers. Therefore, it was suggested that if at the first endoscopy multiple biopsies show a gastric ulcer to be benign, medical treatment of five to six weeks is justified. A second endoscopy and biopsy should then be done and in instances of benign ulceration, repeated every six months unless resection is done earlier. This scheme will diagnose 99.5 per cent of carcinomas of the stomach for effective treatment since malignant degeneration of benign gastric ulcers still remains a hypothesis.

**-Ranes C. C/iakravorty**

### **Severe Diarrhoea Due to Small Intestinal Colonisation During Cimetidine Treatment. W.S. J. Ruddell and M. S. Losowsky. Br. Med. 7.,1980, 281 :273.**

LONG TERM treatment with potent gastric antisecretory agents such as cimetidine may have undesirable nutritional consequences, particularly in the elderly hypochlorhydric patient, who may already have bacterial overgrowth in the small intestine. An instance is presented of a woman, 77 years old, who was admitted to the hospital with chest pain and severe diarrhea, with a weight loss of five kilograms. She was noted to have no ulcer within her stomach on gastroscopy, but a jejunal aspirate confirmed a large overgrowth of enterococci, streptococci, coliforms, staphylococci and bacteroides.

She had been using cimetidine for approximately two months for a duodenal ulcer. Cimetidine causes bacterial overgrowth in the stomach of patients with gastric and duodenal ulcers presumably by reducing acid secretion. A raised gastric pH is associated with an increase in Jejunal bacteria, but a clinical syndrome of diarrhea and malabsorption due to the intestinal bacterial overgrowth has not been convincingly demonstrated in the absence of an anatomic lesion or severe motility disorder. The stagnant loop syndrome has not been satisfactorily documented in a normal small intestine. In this patient, it was presumed to be due to the cimetidine treatment.

**-R. Douglas Yajko.**

**A Simple Technique for Treating Prolapse of the Rectum. (Une technique simple pour traiter le prolapsus du rectum). G. Lagache, J. Guiset and M. Bournoville. Lille Ghir., 1980, 35:49.**

A SIMPLE technique for posterior proctopexy for the treatment of prolapse of the rectum is described. The operation is done through the abdomen with careful packing of the small intestine so as to provide good exposure for the rectum and rectosigmoid. These structures are mobilized by incising the mesosigmoid and the lateral attachments of the sigmoid and rectum so that these structures are freed distally as far as the levator ani muscles. Careful technique is necessary to prevent hemorrhage. After complete mobilization, the rectum and sigmoid are put on the stretch and then fixed to the hollow of the sacrum by three or four sutures placed at the level of the second and third sacral foramina. The rectum and rectosigmoid are attached laterally to the perineum and sacrum. Finally, reperitonealization is done with obliteration of the pouch of Douglas.

The advantages of this technique are that prosthetic material is avoided and the risk of infection is decreased. A single instance of a 70 year old woman with a large prolapse is reported. Two other patients have been operated upon by this technique. There has been no recurrence in these three patients during a two year period of follow-up examination.

**-Frederick W. Preston**

**Transrectal Drainage of Pelvic Abscesses. Charles O. Finne III. Dis. Colon Rectum, 1980, 23:293.**

THE LIMITED experience over a five year period in transrectal drainage of pelvic abscess has led the authors to recommend this procedure. The majority of the ten abscesses were secondary to appendicitis, while diverticular disease, traumatic injury to the colon and incidental appendectomy account for the rest. There were no deaths and morbidity was minimal.

The rectum is the most dependent area in the pelvis and gravity favors drainage from anywhere within the pelvis into the rectum. The intra-abdominal pressure generated to empty the rectum during defecation should also empty the abscess cavity rather than promote its filling.

The presence of a digitally palpable, midline fluctuant mass presenting into the upper or middle rectum is the specific indication for trans-rectal drainage. The technique for drainage includes needle aspiration, dilation with a clamp, digital exploration of the cavity and placement of drains.

**-Albert Barrocas**

**Controlled Trial of Intravenous Hyperalimentation and Total Bowel Rest as an Adjunct to the Routine Therapy of Acute Colitis. Richard S. Dickinson, Michael G. Ashton, Anthony T.R. Axon and others. Gastroenterology, 1980, 79:1199.**

THE ROLE THAT hyperalimentation has in the treatment of inflammatory intestinal disease is believed to be significant. This was a prospective controlled study of 36 patients with inflammatory intestinal disease. The two groups were matched as closely as change allowed for extent, onset and duration of disease. In addition to hyperalimentation, 25 per cent glucose and Freamine II amino acid, synthetic solution, the patient also received bed rest, prednisone and other supportive measures. The outcomes were measured in terms of operative requirements and nutritional status and remission. No difference was found between the groups except that nitrogen sparing was significant in the alimented group. This

study concluded that the course of colitis was not altered by the use of hyperalimentation administered intravenously and total intestinal rest. It should not be used with the expectation that operation may be avoided or delayed.

- **Walter Rohlfig III**