# Selected Abstracts



**Transbronchoscopic Versus Surgical Resection of Tracheobronchial Granular Cell Myoblastomas; Suggested Approach Based on Follow-Up of All Treated Cases. ThOMAS M.DANEL, RODNEY H. SMITH, HOWARD F.FAUNCE and VERNON M.SYLVEST. J.Thorac. Cardiovas. Surg., 1980, 80:898.**

GRANULAR CELL myoblastoma obstructing distal trachea was resected, and primary end-to end anastomosis was performed in a 31 year old woman. Four months after the operation there was no recurrent tumor. It was suggested that the size of granular cell myoblastoma may help to decide whether or not bronchoscopic removal or surgical resection should be performed.

The approach suggested was that the tumor associated with destruction of distal lung tissue should be removed by a lobectomy or pneumonectomy. When the neoplasm was less than 8mm. in diameter, and not associated with distal suppuration or tissue destruction, it should be removed bronchoscopically. A bronchoscopic follow-up examination was necessary over a period of at least five years to rule out recurrence. Tumors cf 8mm. in diameter or more should be removed at thoracotomy, if possible, using lung saving bronchoplastic operations.

**-Dov Weissberg**

**Current Status of Coronary Artery Surgery. JOHN E. CONNOLLY and AKIO WAKABAYASHI Jpn. J.Surg., 1980, 10:89.**

TUE FIRST SUCCESSFUL coronary bypass operation was performed in 1964. A reversed saphenous vein segment was used as the conduit. Previous to that time, coronary endarterectomy and coronary patch graft techniques had been used. The distal anastomoses were done end-to-end until 1968 when oblique end-to-end anastomoses were introduced for the distal connection.

At the present time, 100,000 coronary artery operations are performed annually in the United States. Several observations may be made: successful operation relieves angina pectoris in 80 to 90 per cent of the patients, exercise tolerance is significantly improved and the operation prolongs life when applied to patients with significant lesions of the left main coronary artery. The indications for surgical treatment at the present time are left main coronary lesions and triple vessel disease in patients with good left ventricular function, providing the lesions are technically by passable.

**-Frank J. Miioy**

**Malignant Tumours of the Colon and Rectum in Patients Aged 30 and Younger. J.AHILBERG, 0. BERGSTRAND, B.. HOLMSTROM and others. Acta Chir Scand., 1980, Suppl.500-29.**

ThE RE VvE RE 27 patients with carcinoma of the colon and rectum 30 years old or less in Sweden during 1969 to 1970. Predisposing factors, such as ulcerative colitis and polyposis, were present in 12 of these patients. Those who had a predisposing factor survived an average of only six months postoperatively, with a five year survival of only 16.7 per cent. However, in those young patients with carcinoma of the colon and rectum which arose de novo, the prognosis was at least as good as in older patients, with 60 per cent of the patients surviving five years.

**-Elias Jacobs**

**Carcinoids of the Colon and Rectum in Patients Aged 30 and Younger. J.AHLBERG, O..BERGSTRAND, B. HOLMSTROM and others. Acta Chir Scand., 1980, Suppl 500:33.**

DATA FROM ThE Swedish Cancer Registry during 1960 to 1970 uncovered 26 instances of carcinoid of the large intestine in patients 30 years of age or less. Women outnumbered men by a ratio of two to

one. Almost all had abdominal pain and were operated upon for appendicitis. Alt of the patients but one had the carcinoid localized in the appendix, while in the remaining patient it was in the secum near the base cf the appendix. Most of the lesions in the appendix were in the distal portion.
All patients were treated by appendectomy, except for a limited cecal resection in the patient whose carcinoid was located here. There were no patients with carcinoid syndrome in this group. Five year survival was 100 per cent. A carcinoid tumor smaller than 2 cm. and localized to the appendix should be treated by just appendectomy, even if it penetrates the serosa or mesoappendix. In those lesions greater than 2.0 to 2.5 cm. or if the regional lymph nodes are involved, right hemicolectomy was recommended.
**-Elias Jacobs**

**Gallstone ileus of the Duodenum (Ileus billaire duodenal, Syndrome de Bouveret). G. Grosdidier, C.Lassalle, J.L. Delfosse and others. Lyon Chii., 1980, 76 :289.**
GALLSTONE ILEUS of the duodenum was described by Bouveret in 1886 and to date only 16 instances have been reported. The duodenum is tolerant of large foreign bodies cr gallstones and some of the patients reported upon had no definite symptoms. Two in ore instances of gallstone ileus of the duodenum are presented.
The first patient, a woman 74 years old, was known to have cholethiasis for nine years. She had been sick for three weeks with right subcostal pain, nausea and fever. They had a tender, palpable gallbladder which did not function on cholecystogram. At operation there was an apricot sized stone in the second part of the duodenum.
The other patient, a woman 61 years old, had been sick for two months with vomiting, weight loss of 12 kgm. and no past history of biiary disorders. Her cholecystogram did not function, air was present in her biliary tree and barium swallow showed a large object in the first part of the duodenum. Operation revealed a 6cm., 500 gm. stone.
Both patients had the stone and gallbladder removed, and the cholecystoduodenal fistula closed. It was suggested that in older patients in poor condition, simple duodenotomy and extraction of the stone could suffice and perhaps later repairing the fistula and performing a cholecystoduodenal fistula closed. It was suggested that in older patients in poor condition, simple duodenotomy and extraction of the stone could suffice and perhaps later repairing the fistula and performing a cholecystectomy.
**-William B. Gallagher**

**Suspected Appendicitis; is a Conservative Attitude Advantageous? (Appendicitisverdach; Zuruckhaltende Operations-indikation-ein Varteal?) P.F. AMSLER and K. HELLO Langen-becks Arch. Chr., 1980, 351:193.**
IN ORDER TO determine whether or not indications for appendectomy were too restrictive, the late evolution of 100 patients who were admitted with presumptive diagnosis of appendicitis and later discharged without operation were reviewed. Of 1333 patients admitted during the 3 years period 1970 to 1973, 1,166 were operated upon, 87.5 percent, and operative fmdings corroborated the diagnosis of appendicitis in 8.9 per cent. One hundred and sixty-seven were discharged with a diagnosis of enteritis without operation, 12.5 per cent. Of these, 100 patients could be contacted after a period of five years. There were 34 males and 66 females, with a nean age of 26 years and a range of age from 14 to 77 years old. Three patients, operated within 3 days of discharge, three had subacute appendicitis and two chronic appendicitis.
During the five year postoperative period, 20 of the 100 patients underwent appendectomy. Of the 80 remaining patients, 34 had recurrent symptoms similar to the ones motivating earlier admission. When questioned, 42 of the 100 patients stated that they would have preferred that appendectomy had been performed at the time of their initial admission. The results of the study suggest that a more liberal approach towards appendectomy should be considered for individuals admitted with suspected acute

appendicitis.
**-Erich W. Pollak**

**The Mechanism of the Carbohydrate Intolerance of Cirrhosis. JOSEPH PROIETFO, FRANK P. ALFORD and FRANK J. DTJDLEY. J. Clim. Endocrinol Metab., 1980,51:1030.**
PATIENTS with cirrhosis tend to be carbohydrate-intolerant. Eleven to 35 per cent of patients with cirrhosis are frankly diabetic and the remainder have impaired glucose tolerance. The mechanism of this abnormality remains unknown. Possibilities include insulin resistance, hepatic glucose overproduction or decreased glucose use. Hyperglucagonemia has also been implicated. In an elaborate study of patients in a control group versus patients with cirrhosis, measured insulin and glucagon levels calculated hepatic glucose production and the rate of glucose used.
There was no evidence of glucose overproduction, but there appeared to be decreased glucose use. The cause of this decreased use remains Unknown.
**-Ronald L. Holliday**

**Some Pathophysiological Aspects of Cholestasis. J. Fevery. ActaGastroeneroL Beig., 1979,42:317.**
THE TERM cholestasis or stagnation of the intestine has a different meaning to different people. The physiologist observes a decrease in biiary flow and the pathologist sees disturbances at the canalicular pole of the hepatocyte or pigment accumulation, or both, or bile salt induced changes in liver cells. More at a distance, possible increases in serum levels of conjugated billirubin, bile acids, alkaline phosphate, gamma-glutamy transpeptidase and cholesterol were observed in the clinical chemistry and the physician is confronted with a patient who might complain of jaundice, pruritis, dark urine or pale stools. Several models of intrahepatic cholestasis have been developed recently and are discussed.
In general, alterations of the canalicular membrane composition and fluidity, of the cytoskeleton and the tnicrofflaments and of N a+K+adenosinetriphosphatase have been observed. Further investigations may hopefully lead to an understanding of the pathogenesis of cholestasis.
**-R.Dduglas Yajko**

**Emergency Eradicative Surgical Treatment in Certain Caustic Burns of the Upper Digestive Tract (Plaidoyer pour une chirurgie d'eradication d'urgence dans certaines brulures caustiques majeures du tractus digestif superieur). M. POUYET, P. BOULETREAU and JJ. MOREL.Lyon Chir., 1980, 76:389.**
A 21-YEAR old woman swallowed tranquilizers and a liquid caustic. On admission to the hospital she had respiratory problems from pharyngeal and glotic edema and complaints of epigastric pain. chest plate was negative. The patient was intubated, tracheotomized, started on gastric anti-, acids and alimentation was administered intravenously. An attempt at esophagogastroscopy was unsuccessful. Within two days the epigastric pain was worse and the patient had a right pleural effusion, thoracentesis showed this to be digestive tract fluid. Emergency laparotomy showed necrosis of the stomach, duodenum and upper jejunum, as well as damage to the pancreas.
Total gastrectomy and duodenocephalopancreatectomy was done, the first jejunal anse was also removed. The pancreatic stump was cversewn and the isolated common duct was anastomosed back to the gallbladder, followed by a tube cholecystostomy. The jejunum was drawn up and sutured to the skin as a jejunostomy.
These procedures were followed by right thoracotomy where the esophagus was found to be necrotic and perforated apparently from the endoscope, with mediastinitis and contamination of both pleural spaces. The thoracic esophagus was resected, exteriorizing the cervical esophagus on the right side of the neck.
The patient did well for a while. Five days later at reoperation cholecystectomy and chole-dochojejunostomy were performed and the exteriorized loop cf jejunum was perfectly viable.

Subsequently, the patient had pseudomonas septicemia develop which was resistent to all antibiotics and died nine days following ingestion.
Endoscopic esophageal perforation, which is rare, and jejunal injury in addition to esophagogastric destruction, which is also rare, from swallowing caustics was discussed. The lesion was a coagulation necrosis leading to mediastinitis, peritonitis and septicemia. The appearance of the buocal-pharyngeal mucosa did not permit judging the lesions farther down. Even with extensive esophageal damage, including muscular coat bum, perforation was rare. The stomach was usually hit the hardest, with considerable risk of perforation. The pylorus was a barrier which usually protected the duodenum and upper jejunum, but not in this patient.
Indications for rapid cperation after massive caustic ingestion are the appearance of hydropneumothorax, a sign of intrapleural esophageal perforation, abdominal rigidity, serious upper gastrointestinal bleeding and persistent shock. Studies done with gastrografin, meglucamine diatrizoate, gave no information as to the depth of the burn but confirmed perforation. Endoscopy provided a view of the damage but was difficult and could cause damage.
Early emergency eradicative operation, lateral cervical' esophagostomy, esophagectomy, gastrectomy and if necessary pancreaticoduodenectomy and feeding jejunostomy, with later re-establishment of biliary, digestive and pancreatic continuity are feasible in patients who have ingested caustic, to prevent supra-infection and fatal septicemia.
**-William B. Gallagher**

**Surgical Principles for Pancreatic Cancer, Regional Total and Subtotal Pancreatectomy. JOSEPH G. FORTNER. Cancer, 1981, SuppL, 47 :1712.**
A PE'IEW OF patients who underwent regional pancreatectomy with resection and anastomosis of portal vein or visceral arteries indicated that it has a role in the management of carcinoma of the pancreas. The over-all mortality rate was 15 per cent, which was comparable with other forms of resection. The higher mortality was in the group of patients who underwent regional pancreatectomy with resection and anastomosis of the visceral arteries. The poor results in one subgroup of patients who had resection and anastomosis of the portal vein were due to imprecise patient selection.
One-third of patients were still alive while the remaining patients died from recurrence of disease or other causes. The patients who survived longer, as in other series, had well localized disease, although only two had histologic adenocarcinomas. One unusual finding after operation was a sinc deficiency and the suggestion that immune deficience might be present was also mentioned.
**-Robert TJ. Holl-A lien**