

Selected Abstracts

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Scierosing Cholangitis of the Bifurcation of the Common Hepatic Duct. Basil Golematis, A. Giannopoulos, D.N. Papactiristou and David A.Dreiling. Mt. SinaiJ. Med. N. Y., 1982, 49:38-40.

AN UNUSUAL PRESENTATION of scierosing cholangitis was encountered in a 23 years old patient who had a 40 day history of obstructive jaundice. At operation, a 2 cm. long hard mass was found at the bifurcation of the common duct. The finding of a biopsy of an adjacent lymph node were negative for neoplasia. Cholecystectomy and block resection of the lesion, including a small portion of uninvolved adjacent common and hepatic duct, were performed. An end-to-side cholangiojejunostomy was used to ensure the drainage of bile into the intestine. The patient had an uneventful recovery. Histologic examination of the bifurcation specimen showed a limited scierosing cholangitis and free section margins. The gallbladder had inflammatory infiltration and adenomyosis. In neither specimen was there any neoplasia. The patients had an uneventful recovery.

The criteria for the diagnosis of sclerosing cholangitis include the presence of obstructive jaundice, generalized thickening and stenosis of the biliary channels and absence of gallstones, carcinoma of the bile duct, biliary cirrhosis, retroperitoneal fibrosis or a prior operation of the biliary tree. Differential diagnosis of sclerosing cholangitis with cholangiocellular carcinoma is occasionally difficult to make even when based upon histologic evaluation. In some patients, a true diagnosis is reached only after multiple operations or at autopsy. The preferred treatment for those with diffuse sclerosing cholangitis is biliary stenting and steroid therapy, whereas cholangiocellular carcinoma is best treated by resection and anastomosis. Resection is also the treatment of choice for segmental sclerosing cholangitis to avoid propagation of the process to the rest of the biliary tree.

-Erisch W. Pollak.

Acute Pancreatitis of Biliary Origins; Is Urgent Operation Necessary? John P. Welch and Cathryne E. White. Am.J. Surg., 1982, 143:120-126.

ONE HUNDRED AND TWENTY-SEVEN patients, 81 women and 46 men, with documented pancreatitis caused by gallstones were treated by the authors from 1973 to 1980. Fifty percent of the patients were between 60 and 80 years of age.

Preoperative diagnosis can be difficult. High or normal levels of serum amylase may be misleading. Amylase-creatinine clearance ratios can be more specific. Ultrasonography is a new method that has improved remarkably the diagnostic accuracy. Also, technetium 99m-imino diacetic acid precisely evaluates the patency of the cystic duct and the common duct. Transhepatic cholangiography, which was rarely used, can be 100 per cent accurate.

It is granted that the treatment of definite or probable pancreatitis caused by gallstones is surgical. Nevertheless, 22 patients registered complete improvement without operation, while three other died. The main controversy relates to the timing and the extent of the operative procedure. Some general principles are submitted: catastrophic, fulminating pancreatic inflammation, necrosis or regional abscesses are likely to follow locally invasive investigative procedures or early rough surgical handling of the organs of the area of the hepatic portal. Biliary pancreatitis is usually self-limiting and subsides rapidly without intervention. However, some patients, with and without jaundice, whose conditions are deteriorating must undergo emergency operations.

Consequently, the authors advocate and usually practice delayed operation three to 15 days after admission. Delayed operation was carried out in 77 patients, 60 per cent of the series, and 29, 38 per cent, had serious septic and nonseptic complications. A few needed multiple, recurrent procedures, and five died. A minority underwent emergency operation in the first 48 hours, which resulted in two

deaths, or elective operation, which resulted in three deaths. There was no intervention at all in patients at high risk, those with slow subsidence of the inflammation or the eight who refused operation. Patients who were operated upon were usually younger; 44 per cent were less than 60 years of age. Although some good result with emergency procedures have been published, the authors believe that their own results with delayed operations are very acceptable. The procedures carried out were varied, but the majority were either cholecystectomy alone, 52 patients, or cholecystectomy associated with exploration of the common duct, 39 patients.

-Alfred Metellus.

Mesocaval Shunting in Hemorrhagic Portal Hypertension (L .anastomose measenterico-cave dans l'hypertension portale hemorrhagique. (Reflexion a propps de 42 observations et d'une etude anatomique portant sur 50 dissection)). J.F. Delattre, J.B. Flament, A Burde and J. Rives. *Boni. Med.*, 1981, 14:1305-1310.

DURING the past six years, 556 patients were hospitalized at the surgical clinic of the University Hospital of Reims, France, for hemorrhage of the gastrointestinal tract. Two hundred and one patients of this group had variceal bleeding, 72 died of hepatic insufficiency, and 42 patients had a mesocaval shunting with an interposed graft. Thirty-six of these patients were controlled with an esophageal balloon and were operated upon secondarily after a period of medical preparation of one to three months. In six instances, emergency shunting had to be done because of uncontrollable bleeding. Initially, two catheters are placed, one in the most superior mesenteric vein, the other in one of the terminal veins. Through these, the pressure in the vein is measured as roentgenographic studies are also carried out to demonstrate the anatomy of the superior mesenteric vein where it joins the portal vein. A side-to-side graft is then done between the lateral aspect of the inferior vena cava and the superior mesenteric vein using an 18 mm. Dacron, polyester fiber, graft. Further roentgenograms are taken, and postoperative pressures are documented.

The operative mortality was 21 per cent within one month of the operation; five of six patients who underwent emergency operations died, compared with four of 36 whose procedure was elective. There were no operative deaths among 15 patients with Child's Class A disease, whereas five 20 with Class B disease and four of seven with Class C disease died after operation. None of the patients with Child's Class A disease died, whereas none of those with Child's Class C disease survived for more than two years.

Among the 22 surviving patients who were observed for six months to six years, morbidity has been minimal. Eighteen went back to normal activity, three had progression of cirrhosis and had jaundice develop, and two required multiple hospitalizations for encephalopathy. Fifteen of these 22 patients were reinvestigated, and the shunt remains functioning in 13.

It is concluded that later-lateral mesocaval shunting with an H graft is always anatomically possible, although technical expertise might be needed. The partial derivation of the portal stream avoids sudden hepatic ischemia in these patients who already have border line hepatic function. This operation seems to be indicated for patients with Child's Class A disease. The clinical decision is more difficult for those with Class B disease, and the procedure is probably not indicated for patients with Class C cirrhosis of the liver. The results of the procedure are uniformly bad for patients who are still bleeding, and therefore, the operation should be served for situations in which control of the hemorrhage is not possible by more conservative means.

-Ranes C. Chakrawarzy.

Risk Associated with Diabetes Mellitus in Patients Undergoing Gallbladder Surgery. Daniel B. Walsh, Frederic E. Burney, *Surgery*, 1982, 91: 254-2 57.

THE QUESTION of the risk to patients with diabetes undergoing operations of the gallbladder was studied. Of 80 patients with diabetes, 29 had acute cholecystitis and 51 had chronic cholecystitis or

cholelithiasis. Of 95 patients without diabetes, 39 had acute cholecystitis and 56 had chronic cholecystitis or cholelithiasis. Morbidity and death occurred most frequently among patients with acute cholecystitis who also had evidence of vascular or renal disease. This finding was true regardless of the presence or absence of diabetes mellitus. The mortality of this group was 29.2 per cent, and that of patients with renal dysfunction, whether diabetic or not, was 25 per cent.

Mortality and complication rates were nearly identical in both the nondiabetic and the diabetic population. Therefore, it is concluded that diabetes mellitus alone does not appear to adversely affect the prognosis of patients who require surgical procedures of the gallbladder.

-John J. Hudock.

Hepatic Abscesses; Changes in Etiology and Recent Diagnostic Improvements with Reference to 29 Patients (Gli ascessi epatici: modificazioni nell-etiotopogenesi e recenti progressi diagnostici con riferimento al 29 casi osservati). Paolo Cappellini, Luciano Donnini, Eugenio Pecchioli and others. *Osp. Ital. Chir.*, 1981,34 : 331-336.

TWENTY-NINE PATIENTS with an abscess of the liver were managed between 1949 and 1979. Most patients were between 30 and 50 years of age. Seventeen of the patients, 59 per cent, had undergone an operation of the biliary tract recently; six had undergone an operation for a hydatid cyst of the liver, two an appendectomy, one patient a splenectomy and one patient each an operation for pancreatitis, amebiasis and typhoid fever. One hundred per cent of these patients had fever, 96 per cent had pain, 90 per cent had hepatomegaly, 45 per cent had jaundice, and 65 per cent had leukocytosis.

Between 1949 and 1965, the chief diagnostic tool was roentgenograms of the chest and abdomen, on which radiopaque areas and air-fluid levels and elevation and immobility of the right side of the diaphragm with opacification of the right side of the costophrenic sinus are looked for. Results of cholecystocholangiography, barium contrast studies of the upper gastrointestinal tract and celiac arteriography did not furnish much information of value.

Since 1965, results of liver scans, echotomography and computerized tomography have facilitated earlier and more exact localization of hepatic abscesses. The bacteriologic conditions of these hepatic abscesses showed, in decreasing order of frequency, *Escherichia coli*, *Proteus vulgaris*, *Klebsiella aerogenes*, *enterococcus* and *staphylococcus*. Two patients were treated with antibiotics alone after undergoing diagnostic aspiration. The remaining 27 were also treated by surgical drainage.

Seven of the 29 patients, 24 per cent, had suppurative hydatid cysts, six in the right lobe and one in the left. Of the remaining 22 patients, 16 had single abscesses, 15 in the right lobe and one in the left. Six patients had multiple abscesses. The mortality before 1965 was 28 per cent, and since then, it has been 13 percent. Over-all, patients with multiple abscesses had a 50 per cent mortality, and patients with a single abscess had a 13 per cent mortality.

-William B. Gallagher.

Effect of Cimetidine on Portal Hypertension in Cirrhotic Patients. A.K. Burroughs, R. Walt, A. Dunk and others. *Br. Med. J.*, 1982, 284: 1159-1160.

TWELVE PATIENTS were studied in this report of the effect of intravenously given cimetidine upon the gradient between the wedged and free hepatic venous pressures, thought to be a reliable index of portal pressure. These were patients who were admitted consecutively, with bleeding esophageal varices, and they were studied three days after the bleeding had stopped. After the patient was settled, three recordings of wedged and free hepatic venous pressures were taken over 10 minutes. Cimetidine, 200 mgm., was then given intravenously, and after 10 minutes, three more pressure measurements were made.

The means of the pressure gradients before, 16.8 ± 4.2 mm. Hg, and after the administration of cimetidine, 16.1 ± 3.1 mm. Hg, did not differ significantly. It is concluded that cimetidine probably does not reduce splanchnic blood flow, and therefore, results of prospective trials of prophylaxis for

bleeding esophageal varices with cimetidine are likely to be disappointing.

-Gordon L. Kauffman, Jr.

Biliary Bacteria; Significance and Alterations After Antibiotic Therapy. Henry A. Pitt, Russell G. Postier and John L. Cameron. Arch Surg., 1982, 117 : 445-449.

ONE HUNDRED AND THIRTY-FOUR patients having urgent and complex operations of the biliary tract were studied to determine whether or not bacteribilia is an important risk factor for these patients and how surgical procedures and therapy with antibiotics influence the bacteriologic characteristics of bile. Those patients undergoing choledochotomy or exploration for obstructive jaundice had aerobic and anaerobic cultures of bile obtained at operation and postoperatively. Postoperative complications were correlated for the presence of bacteria and operative biliary cultures. These patients were observed for a wound or intra-abdominal infection, bacteremia, an infection of the urinary tract, pneumonitis, renal failure and hemorrhage of the upper gastrointestinal tract.

Several factors were associated with statistically significant increases in biliary bacteria compared with the rest of the population. These included a benign stricture, choledocholithiasis, preoperative cholangitis and an age greater than 60 years.

Patients who had renal dysfunction or a wound infection occur postoperatively were more likely to have bacteria present in their bile at operation. The relationship between biliary bacteria and wound infection supports the concept that the own flora of the patient accounts for most operative infections. Factors which contribute to the colonization of bile postoperatively include the creation of a biliary enteric anastomosis, contamination of the biliary drainage system and the presence of a drainage tube, which is a foreign body that causes partial obstruction.

In summary, three recommendations are made. First, an antibiotic with anaerobic coverage, including coverage for *Bacteroides fragilis*, should be included in the initial management of elderly patients with cholangitis. Second, prolonged administration of an aminoglycoside should be avoided, particularly to elderly patients with bacteribilia. Third, the use of a closed biliary drainage system with strict adherence to sterile technique in its management should be encouraged to avoid contamination of bile by antibiotic resistant organisms.

-Richard L. Zeff.

Our Experience with Splenectomy: 453 Observations (L'nostra esperienza in tema di splenectomia: 453 osservazioni; Nota 2 Risultati). Luca manneschi, Piero Burci, Massimo Tofani and others. Osp. Ital. Chir., 1981, 34: 517-536.

FOUR HUNDRED AND FIFTY-THREE splenectomies were done with only a 3.0 per cent complication rate and a 1.3 per cent mortality. Indications included traumatic ruptures in 31 patients, primary panhypersplenism in 11, thrombocytopenic purpura in 41, hemolytic anemia in 13, chronic lymphatic, leukemia in 4, chronic myeloid leukemia in 6, Hodgkins' disease in 217, non-Hodgkin's lymphoma in 19, cirrhosis with hypersplenism in 47 and accidents in connection with gastric or esophageal resection, repair of a hiatal hernia or other operations in 49.

All the splenic beds were drained, a procedure which the authors believe prevented subphrenic hematomas and abscesses. The authors consider splenectomy a useful and safe operation but refer without comment to reported occurrences of postsplenectomy sepsis in infants, which they believe "is probably due to the irreplaceable importance of the spleen in determining immune defenses."

- William B. Gallagher.

How Effective is Surgical Adrenalectomy in Lowering Steroid Hormone Concentrations? T.J. Worgui, R.J. Santen, E. Saxen and S.A. Wells. J. am. Endocrinol. Metab., 1982, 54: 22-26.

ALTHOUGH it is accepted that regression of tumors will occur in 30 per cent of unselected women with metastatic carcinoma of the breast and in 50 to 60 per cent of such women with estrogen receptor-

positive tumors when bilateral adrenalectomy is performed, little information is available concerning the effects of the operation upon circulating hormone levels. Twenty-six postmenopausal patients whose hormones were measured by sensitive immunoassay techniques before and after surgical adrenalectomy for their disease are reported upon.

In this group, both androgen and estrogen concentrations were suppressed, whereas plasma levels of polypeptide hormones of the pituitary gland remained unchanged. All measured androgens fell significantly, and plasma and urinary estrogens were also lowered by the procedure in the groups as a whole. About 20 per cent of the patients had residual estrogen activity, however, and several patients were shown to improve after either immunoglutethimide or tamoxifen, which reveals that residual estrogen produced after adrenalectomy is biologically active.

The progressive regrowth may be the result of the regrowth of adrenal fragments from operation, hypertrophy or accessory adrenal glands. Another as yet unproved possibility is that estrogen may come from dietary sources of residual estrogen. The results of these studies may show why some patients whose disease progresses following remission after adrenalectomy subsequently demonstrate remission of tumor after receiving either tamoxifen or aminoglutethimide.

- Thomas S. Reeve