

Selected Abstracts

Pages with reference to book, From 151 To 153

Management of Crohn's Disease Involving the Duodenum, Including Duodenal Cutaneous Fistula. Terrence J. Fitzgibbons, Gerald Green, Howard Silberman and others. Arch. Surg., 1980, 115:1122.

INVOLVEMENT of the duodenum by Crohn's disease is rare and usually occurs in patients with disease elsewhere in the alimentary tract. Seven patients with Crohn's disease involving the duodenum are reported and two of these patients had duodenoenterocutaneous fistulas. Fistulas arising from primary duodenal disease are extremely rare. Secondary involvement of the duodenum by Crohn's disease arising in the ileum or colon is the usual cause of most Crohn's enteroduodenal fistulas. Crohn's disease of the duodenum may occur initially with vague symptoms suggestive of atypical ulcer disease or symptoms related to other diseases of the intestine. It can produce the complications seen with Crohn's disease at other intestinal sites including obstruction, perforation, fistula, abscess and hemorrhage. The disease commonly involves the duodenal bulb and descending duodenum but may extend into the distal duodenum as well. All the roentgeno-graphic changes seen with Crohn's disease elsewhere in the intestine may be manifest in the duodenum. Endoscopy may be helpful and specimens taken at biopsy may show the abnormal mucosal lesions.

The treatment of Crohn's disease involving the duodenum should be primarily medical and seems to be successful in the majority of patients. Total parental nutrition and bowel rest may produce prolonged remissions and is being evaluated. In this series, nonoperative therapy was successful in four of seven patients. Operative therapy should be withheld unless specific surgical indications such as obstruction, bleeding or fistulas develop. Resection of duodenal disease is rarely warranted due to the magnitude of surgical treatment in this area. Gastroenterostomy would be the treatment of choice for obstruction and bypass with suture ligation of bleeding vessels may be sufficient for hemorrhage. Tagotomy may be added to assist in acute control of hemorrhage. Internal fistulas to the duodenum are best treated by excision of the fistula and primary repair of the duodenal wall. The management of external fistulas to the duodenum is not clearly established, but two patients in this series were successfully treated with excision of the fistula and simple closure of the duodenum, despite involvement of the wall by disease in one instance.

-Robert W. Painter

The Gastrointestinal Manifestations and Complications of Malignant Lymphoma. Sherlock. Schweiz. Med. Wochenschr., 1980, 110:1031.

THE GASTROINTESTINAL tract may be the primary site of lymphoma, but more commonly, it is secondarily involved. Three hundred and twenty-three patients who died of lymphoma underwent autopsy and 50 per cent were found to have involvement of the gastrointestinal tract. The pancreas was the most common site. The stomach was the primary site in 3 per cent of the malignant disease of the stomach; whereas, the incidence in small intestine is 40 to 50 per cent of all malignant disease. Twenty per cent had multiple lesions. The colon and rectum are rare sites. Since there has been improvement in the survival of Hodgkin's and non-Hodgkin's lymphoma, the incidence of complications of the disease and treatment are on the rise. Massive gastrointestinal hemorrhage is rare, but when it occurs, it is most commonly due to stress ulcers in Hodgkin's disease. These patients were receiving therapy either in the form of steroids or chemotherapy. Several patients also had evidence of sepsis. Since the cause of bleeding is a benign condition, vigorous diagnostic and therapeutic effort should be made. Fungal infections, particularly moniliasis, is a common complication also and more commonly involves the esophagus. Patients who are on steroids, radiation or chemotherapy are potential candidates. Treatment

is usually carried out with nystatin or amphotericin B. Malabsorption is also commonly seen and some patients may present with symptoms of malabsorption. The usual pathologic characteristics responsible for this is either extensive involvement in lymph nodes causing lymphatic obstruction or diffuse infiltration of small intestines with loss of villus architecture. Pancreatic insufficiency due to involvement of the pancreas may also cause malabsorption.

Benign lymphoid hyperplasia associated with chronic peptic ulcer in the stomach has also been seen. These patients have a long benign course. Association of ulcerative colitis and lymphoma has also been seen, but the incidence is much less than carcinoma.

Complications that are seen following different treatment methods are dumping syndrome, hypoglycemia and steatorrhea after gastrectomy, diarrhea and bleeding following radiation, gastric and duodenal ulcer, gastrointestinal moniliasis, diarrhea, malabsorption and mucosal ulceration and at times, complete necrosis of intestinal villi following chemotherapy.

-S.P. Girdhar

Clinical Trial of Jejunoileal and Gastric Bypass for the Treatment of Morbid Obesity Four-Year Progress Report. Joseph et al. Buckwalter. Am. Surg., 1980, 46 :377.

THIS REPORT of a randomized prospective clinical trial comparing jejunoileal bypass and gastric bypass describes 38 patients four years after the beginning of the study and two years after the conclusions of the series. The series was discontinued because of the observed and reported complications of the jejunoileal bypass. Criteria for surgical treatment included excess weight of 45 kgm., or more above normal for 5 or more years. The jejunoileal bypass procedure was performed using a 30 cm jejunal segment and a 15 to 20 cm. ileal segment. The gastric bypass operation used a 10 to 14 per cent proximal pouch.

The patients who underwent jejunoileal bypass operation, achieved a greater degree of weight loss at one, two and three years, but the sequelae and complications were much greater in the first group. These included enteritis, urinary calculi, fatty infiltration of the liver, persistent diarrhea, electrolyte imbalance and metabolic disturbances. Patients who underwent gastric bypass operation, tended to have cholelithiasis and bile reflux develop. One anastomotic leak occurred. The number and severity of complications was less in the gastric bypass group.

After the clinical trial was concluded, 31 subsequent gastric bypass operations were performed using the TA90 stapling instrument to create a partitioning of the stomach with a 50 ml. proximal pouch. This resulted in an increase in weight loss and fewer complications. It was concluded that the gastric bypass operation with staples produces fewer complications and a satisfactory weight loss in the majority of patients.

-Don L. McCord

Thiazides and Acute Cholecystitis. Lynn Rosenberg, Samuel Shapiro, Dennis Slone and others. N. Engl. J. Med., 1980, 303:546.

DURING A ROUTINE screening of data from a patient-control drug-surveillance program, an association between the use of thiazide containing drugs and acute cholecystitis was found. There were 2,095 patients: 419 patients with acute cholecystitis and 1,676 patients in the control group. Within the 95 per cent confidence limits, there was a relative risk estimate of 2.0 for patients who used thiazides in the month preceding admission as compared with patients who had never used these drugs. There was a significant increasing relative risk with the duration of use. Patients who had used thiazides for five or more years had a relative risk of 2.9. Confounding did not explain this association. The results of this study indicate the need for further evaluation of this apparent association.

-Robert P. Davis

Etiology and Pathogenesis of Acute Biliary Pancreatitis. J.M. Acosta, C.A. Pellegrini and D.B.

Skinner. Surgery, 1980, 88:118.

IN 1972, a new therapeutic approach for acute gallstone pancreatitis was developed at the National University, Rosario, Argentina. It consisted of immediate operation upon all patients with acute pancreatitis and concomitant biliary tract obstruction, provided that the patient had been admitted within 48 hours of onset of symptoms and was a reasonable surgical risk.

In 78 patients with acute pancreatitis associated with gallstones, anatomic inspection, operation or autopsy, was performed during the acute stage of the disease. The patients presented with typical clinical signs and with concomitant biliary obstruction. Sixty-three per cent had a history of dietary abuse before the crisis. Thirty-three per cent had a concomitant biliary tract insertion. Impacted gallstones at the ampulla were found in 49 of the 78 patients, 63 per cent. According to the cholangiographic findings four types of obstruction were seen; total low obstruction, 43 per cent; total low obstruction with reflux to the Wirsung's duct 23 per cent; total high obstruction, 13 per cent and partial obstruction, 21 per cent. In each patient, the gallstones removed from the ampulla were identical to those found in the gallbladder.

The pathologic changes found in the pancreas were grouped under four different grades according to the degree of lesion found; grade 1, edema, 36; grade 2, fat necrosis and peritoneal exudate, 16; grade 3, hemorrhage, 11 and grade 4, massive necrosis, abscess, or pseudocyst, 15. The degree of pancreatic lesion directly correlated with the duration of ampullary obstruction in 49 patients, in whom a stone was still impacted at the time of anatomic inspection. The dietary excess before the pancreatitis and the cholangiographic evidence of reflux to the Wirsung's duct were not observed to correlate with the severity of the pancreatitis. Patients with biliary tract infection presented with more severe pancreatitis. The relief of obstruction obtained through operation within the first 48 hours was followed by complete and immediate recovery in 98 per cent of the patients.

The results of the present study prove that acute biliary pancreatitis is caused by ampullary obstruction due to migration of gallstones. Rapid remission occurs if patency of the ampulla is restored before 48 hours. After prolonged ampullary obstruction more severe pancreatic lesions, some of them irreversible, may develop.

-Orville F. Grimes

Spontaneous Disappearance of Large Stones from the Common Bile Duct. Raymond C. Evans, Jur V. Kaude and William Steinberg. Gastrointest. Radiol., 1980, 5:47.

THE AUTHORS HAVE encountered a nonjaundiced patient with three large nonobstructing common duct stones delineated by intravenous cholangiography. The common duct was dilated and tomograms indicated that the largest stone was 15.4 mm. After a month of abdominal colic, the symptoms subsided and three months later repeat cholangiography showed no stones and a normal sized duct. It was concluded that the stones passed spontaneously, since there was no sign of fistulous connection. The need to reexamine the biliary tree preoperatively when symptoms have subsided was emphasized.

-John H. Wulsin

Facts and Fallacies of Common Bile Duct Obstruction by Pancreatic Pseudocysts. Andrew L. Warshaw and David W. Rattner. Ann. Surg., 1980, 192:33.

ALTHOUGH IT IS commonly accepted that pseudocysts of the pancreas can cause obstruction of the common bile duct, most instances of obstructive jaundice associated with pseudocysts appear to be due to fibrotic stricture of the intrapancreatic portion of the common bile duct, rather than to pressure on the duct by pseudocyst. Three additional patients are presented; two in whom fibrosis and not the pseudocyst caused the biliary obstruction. The authors stress the importance of performing intraoperative cholangiography after drainage of the pseudocyst and the necessity of a biliary-enteric bypass if bile duct obstruction has not been relieved by simple decompression of the pseudocyst.

-Robert K.T. Liem

