Outcome of severe head injuries in Central Africa, Walters D.A.K. and Sinclair J.R., Lusaka, Zambia, Journal of the Royal College of Surgeons of Edinburgh, 1988, 33, 35-38.

This report comes from the University Teaching Hospital. No neurosurgeon was available in Zambia. 214 patients were admitted to the ICU. 63.5% were the result of road traffic accidents and 30.8% were due to assaults. Hospital mortality was 52%. Patients with a Glasgow Coma Scale (GCS) 3-5, had a 91.5% mortality. 20% died from extradural and 67% from subdural hematoma. 17% of ICU admissions were for head injuries. The percentage of unfavourable outcomes (dead vegetative or severely dependant) with GCS of 3-5 is 76-80% in western centers with CT scan and intracranial monitoring facilities which were not available here. Interestingly, none of the Zambian patients were left in a vegetative state. The authors suggest this may be due to poor nursing care in the ward resulting in lethal respiratory tract infections. The authors also mention that ventilation and ICU care for Glasgow Coma Scale 3-5 patients is unrewarding and this may be an important factor when deciding which patient is entitled to limited ICU beds in third world settings.

Ureterosigmoidostomy and bladder exstrophy: a long term follow up. Zabbo A., Kay R., J Urol, 1986, 136: 396-398.

From 1925 to 1970, 128 patients had ureterosigmoidostomy (USO) and excision of the bladder. Seventy six had died by the time of review of the remaining 52, 34 still had functioning USO, but 18 had revision conversion of USO to cutaneous diversion (11 for recurrent infection, 3 for fecal incontinence, 4 for colonic cancer). 11% of patients surviving 15 years after USO had colon cancer. Reviewing another period, 1965-1981, the authors had done USO in 38 patients.

None died, 5 had complications requiring hospitalisation (metabolic acidosis in two, unilateral stone in two, benign polypous tumour in one). The authors claim good results but still suggest yearly sigmoidoscopy beginning 10 years postoperatively.

(T.J.)

Horsehoe kidney in children. Wilson C., Aazmy A.F., Br J Urol, 1986, 58 : 361-363.

The author saw 20 children with horseshoe kidneys in a 10-year period. Males predominate. Mean age was 5.7 years. The diagnosis was made during investigation of urinary infection (8), hematuria (2), eneuresis (2), loin pain, abdominal mass and renal trauma (3) or cardiac catheterisation (5). Reflux was seen in five patients. Seven had congenital heart disease, four had other abnormalities. Nephrectomy was needed for poorly functioning moiety, hypertension or nephroblastoma.

Pelviureteric obstruction in children treated by retrograde ureteroplasty. Doraiswamy N.V. and Bader M.J.K. (Kuwait), Brit J Urol, 1989, 63 : 141-143.

The authors treated two children (age 6 and 7 years) with congenital PUJ obstruction by Fogarty balloon dilatation. An 18 month follow-up showed improved drainage and function.

Gram-negative intestinal bacteria, gastric colonisation and postoperative pulmonary complication. Parr N.J. et al, (Merseyside, UK), Journal of the Royal College of Surgeons, Edinburgh, 1988, 83, 9-12.

The authors draw attention to the fact that in postoperative patients, culture of the expectorated pus in patients with radiographic findings often grows gram-negative intestinal bacteria (GNIB). The organisms colonise the trachea in 50% of ventilated patients in intensive care units (ICU). Gastric colonisation preceeds tracheal events. The authors found GNIB in 12% of postoperative general surgical patients who had not received antibiotics. All had purulent sputum, and 60% had radiographic changes. In patients with nasogastric tubes gastric colonisation could be demonstrated in some but did not always preceed respiratory tract colonisation. These authors noted that nasogastric intubation did not predispose to respiratory infections. Groups at high risk for developing a gastric reservoir of GNIB are patients on H2 receptor blockers, post gastric surgery, pernicious anemia and prolonged postoperative ileus. These findings are of importance as others have recently shown tracheal aspiration of nasogastric contents in upto 60% of patients during surgery, detected by a tracheal pH electrode. Prophylactic antibiotic therapy used to prevent wound complications may increase gastric colonisation with GNIB.

CO_2 laser surgery for the breast: A comparative clinical study, Ansanelli, V.W., Lasers Surg Med, 1986, 6:470.

Two hundred and nine patients with breast cancer had biopsy of mastectomy for cancer, 105 by laser knife, 104 by cold knife. Laser reduced the incidence of seromas and shortened drainage time, reduced hospital stay by 1/3 and hastened return to normal activity.

(T.J.)

ABSTRACTS

Cholangitis: H. Kinoshita et al (Osaka, Japan), World Journal of Surgery 1984, 8, 963–969.

The authors studied 125 patients with acute cholangitis and divided these into three groups: 1) Acute cholangitis characterised by infection, (fever, chills, leucocytosis and abdominal pain) and biliary tract obstruction (jaundice, elevated serum bilirubin or alkaline phosphatase); 2) Acute suppurative cholangitis diagnosed when the bile contained pus detected after percutaneous drainage or at laparotomy or post mortem; and 3) Acute obstructive suppurative cholangitis (AOSC) where symptoms of septic shock supervened. This classification appears inappropriate and a better term for the AOSC would be cholangitis with septicemia. In 12 of the 19 cases in AOSC group plasma endotoxin levels measured by the Limulus test were elevated. Laparotomy decompression of the common bile duct resulted in 4 deaths in 8 patients in the AOSC group. 7 of 11 patients treated by percutaneous drainage recovered from shock. In an experiment seven days after ligation of the common bile duct, 1.5 or 3.0 mg/kg of endotoxin (E. coli) was injected into the hepatic duct. Saline was then used to raise pressures to 150, 200 and 250 mm H20. At 150 and 200 mm H20, the hepatic venous and femoral arterial blood were free of endotoxin. At higher pressures all (13) dogs had positive tests for endotoxin in the vein and artery. This demonstrated that cholangiovenous reflux occurs.

The authors recommend percutaneous decompression (in preference to laparotomy) of the hepatic biliary tree even for patients with septic shock.

(T.J.)

Anterior transperitonial approach to the upper urinary tract with one stage bilateral procedure. Jane A.B., Young C.H. (Birmingham), Brit J Urol, 1989, 63: 239-242.

The authors performed 87 procedures for benign renal conditions through a transperitonial approach. This approach does not increase the risk of paralytic ileus or infection. 25 patients had Anderson Hynes procedure. 20 had pilolithotomies and one a partial nephrectomy, Elected appendectomy, cholicystectomy and para-umbilical hernia repair were done concurrently. Urinary leaks developed in 10 patients; 8 of them needed a stent. None developed peritonitis. The average stay for 63 nephrectomies was 12.68 days (3-48 days). Average stay after stone removal was 11.35 days (7-22 days), and after piloplasty (15 days).

(T.J.)

Loop Ileostomy: A Superior Diverting Stoma in Colorectal Surgery. S. Frasth and L. Hulten (Goteborg, Sweden). World Journal of Surgery, 1984, 401–407.

The authors, basing their comments on a series of 99 loop ileostomies feel that it is superior to transverse colostomy when temporary diversion of the fecal stream is needed.

A loop of bowel was brought out onto the skin from which 2 cm diameter disc was removed after the hole in the abdominal wall was dilated to 2 finger size. The site was 15–20 cm proximal to the ileocaecal valve, or the ileocolic anastomosis. In reservoir patients the loop was 60–70 cm above the pouch. The authors recommended turning the loop clockwise so that the proximal opening is placed below and the distal opening above. A glass rod through the mesentery was used and the only sutures were mucocutaneous sutures. Closure of the loop was easily accomplished without a formal laparotomy.

The ileostomy started functioning on the first postoperative day. Peak output occurred on the 3rd and 4th postoperative day (1200 ml) and stabilised to about 650 ml (360–1610) at time of discharge. Transient edema and obstructive symptoms developed in the majority of patients in the first week. Prolapse of the ileal loop occurred. 12% patients developed a transient leakage and sore skin. Complications of ileostomy closure include wound infection, intestinal obstruction. An ileostomy is advantageous in patients with a short mesocolon, obese patients and patients with malignant tethering of the transverse colon. In patients with colonic obstruction there must be clear evidence of incompetent ileocaecal valve before doing a loop ileostomy.