Thorax (1952), 7, 354.

ABSTRACTS

This section of THORAX *is published in collaboration with the abstracting journal,* ABSTRACTS OF WORLD MEDICINE, *published by the British Medical Association. In this* JOURNAL *some of the more important articles on subjects of interest to chest physicians and surgeons are selected for abstract, and these are classified. No one section is necessarily represented in any one issue.*

Thoracic Surgery

Reflux Esophagitis, Sliding Hiatal Hernia, and the Anatomy of Repair. ALLISON, P. R. (1951). *Surg. Gynec. Obstet.*, **92,** 419.

"The aim of this paper is to emphasize the relation between the altered physiology of the cardia and a common form of indigestion consisting mainly of heart-burn, gastric flatulence, and postural regurgitation." After a detailed and clear account of the anatomy of the parts around the oesophageal opening of the diaphragm there is a description and differentiation of the two main types of hiatal hernia. The first is the para-oesophageal and consists of a preformed sac in front of the oesophagus; into this sac the stomach and the great omentum may "roll," but the cardia is not disturbed and by itself this type does not permit of regurgitation. The second type, which is called sliding hiatal hernia, results when the hiatus is enlarged and the tissues surrounding the oesophagus at the hiatus (the phreno-oesophageal ligament and peritoneal reflexions) become loose and stretched so that the cardia can slide up into, or down from, the mediastinum. In this type regurgitation of gastric contents into the gullet occurs and causes the characteristic burning, radiating pain and flatulence.

Within 5 years the author saw 204 patients with hiatal hernia. Not all needed, or were fit for, operation. Of 73 patients with sliding hernia and oesophagitis only 33 were operated upon, with 1 death which occurred 6 days after operation from coronary thrombosis. The technique of the operation for sliding hiatal hernia is described. The chest is opened through the bed of the 8th or 9th left rib. The posterior mediastinum, the left phrenic nerve, and the solar plexus are infiltrated with an analgesic. An inverted T-shaped incision is made in the mediastinal pleura, the oesophagus is isolated above the cardia, and a tape is passed round it for traction purposes. A separate incision is made through the dome of the diaphragm, and by inserting 2 fingers through this and pushing them through the hiatus the redundant and lax tissue and peritoneal reflexion can be identified and excised. By means of the tape the cardia can be drawn below the diaphragm and the cut edges of the redundant tissue sewn to the under aspect of the diaphragm. The lax fibres of the right crus can then be approximated by 1, or at most 2, loose silk sutures. The diaphragmatic and chest-wall incisions are closed. An underwater tube is left in place to pass obliquely out through the wound, but this is removed before the patient returns to the ward if an *x*-ray photograph taken on the operation table shows that both lungs are fully expanded.

Zachary Cope.

One-Stage Resection of the Thoracic Oesophagus for Carcinoma Localized above the Aortic Arch, followed by Subpharyngeal Oesophago-gastrostomy. [In English.] NUBOER, J. F. (1951). *Arch. chir. neerl.*, **3,** 57.

Growths in the upper part of the oesophagus are difficult and dangerous to remove, and excision is possible only in a limited number of cases. Anastomosis has often to be made in the neck between the stomach, which has previously been freed, and the upper end of the oesophagus.

A single-stage operation is here described in which excision and restoration of continuity were performed, starting with a third-interspace thoracotomy which allowed the growth to be mobilized. The incision was then carried downwards and a second thoracic incision was made in the seventh intercostal space. Through this opening the lower oesophagus was mobilized, the diaphragm was split, and the stomach freed from its attachments. The stomach was then brought up into the chest and the lower end of the oesophagus was divided. The arch of the aorta was mobilized after dividing the upper 2 intercostal vessels; the stomach was drawn behind this, and a ligature was attached to the stomach at its new upper limit. The chest was then closed and the cervical oesophagus exposed in the neck. The stomach was drawn into this opening and anastomosed immediately below the pharynx.

The patient supported the operation well and 5 months later was in good condition. *T. Holmes Sellors.*

Technique of Left-sided High Thoraco-laparotomy. Indications in the Surgery of the Thoracic Oesophagus. RUDLER, J. C. (1951). *J. Chir., Paris*, **67,** 233.

The combined Lewis–Santy approach to the oesophagus is eminently satisfactory for growths of the middle third, especially where the growth is situated behind the aorta. For growths of the lower third and where total gastrectomy may be necessary the author regards a single left approach advisable. His approach affords a very much better exposure and avoids the necessity of turning the patient during the operation. The incision is an angular one, opening the thorax through an intercostal space, dividing the costal cartilages, and entering the abdomen obliquely to the left of the mid-line. The diaphragm is split and the phrenic nerve cut or avoided. A very wide exposure is obtained of the lower chest and whole upper abdomen. This approach may be used for radical surgery or for a palliative oesophago-gastrectomy. Five cases of radical surgery are described, and 7 of palliative operations.

[This article is characterized by excellent anatomical details and a fine series of pictures.] *R. J. Burkitt.*