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Dr. James Fallis
2.

PROGRAMME

TUESDAY JANUARY 20th

1000 - 1700 hrs  Meeting of Council, Chateau Frontenac, Salon Quebec
1900 hours       Informal Reception and Dinner, Council Members & wives

WEDNESDAY JANUARY 21st

0815 hours       Bus, Chateau Frontenac to Centre Hospitalier - De L'Universite Laval
0900 hours       Annual Business Meeting, Coffee
1100 - 1230 hours Scientific Session A

Louis Levesseur and Graham Fraser, Chairman
F.G. MacLeod Lecture, Scientific Papers

1230 - 1400 hours Lunch

1400 - 1700 hours Scientific Session B

Harvey Beardsmore, Chairman
Guest Lecture and Scientific Papers

1700 hours       Bus to Chateau Frontenac

1900 hours       Presidential Reception, Salon Rose

THURSDAY JANUARY 22nd

1400 - 1700 hours Joint Session with Royal College C
Jim Simpson, Chairman
Room 3 Convention Centre
Guest Lecturer, Scientific Speakers, and Panel
WED. JAN. 21 0900-1200

AUDITORIUM CENTRE HOSPITALIER DE L'UNIVERSITE LAVAL

Annual Scientific Meeting Session A

canadian association of paediatric surgeons

CHAIRMAN: DR. L. LEVASSEUR, Quebec

0900 ANNUAL BUSINESS MEETING

1030 COFFEE INTERMISSION

1100 GUEST LECTURER

A.1 TERATOMAS OF THE CHILDREN

DR. D. PELLERIN, Hôpital Necker Enfants Malades, Paris

ABSTRACT NO.

A.2 1130 TESTICULAR SCANNING FOR TESTICULAR TORSION — AN IMPORTANT NEW DIAGNOSTIC AID: B. Shandling, D. L. Gilday, D. C. Hitch, Hospital for Sick Children, University of Toronto, Toronto.

WED.
JAN. 21
1400-1700
AUDITORIUM CENTRE HOSPITALIER DE L'UNIVERSITE LAVAL

canadian association of paediatric surgeons

Annual Scientific Meeting: Session B

CHAIRMAN: DR. H. E. BEARDMORE, Montreal

1400 LECTURE AND DISCUSSION

B.1 EXAMINATION OF THE EYE IN PAEDIATRIC EMERGENCY CIRCUMSTANCES
DR. TREVOR KIRKHAM, Director, Department of Ophthalmology, Montreal Children's Hospital, Montreal.

1500 COFFEE INTERMISSION

ABSTRACT NO.

B.2 1530 SEVERE FEEDING PROBLEMS IN CHILDREN WITH INTRA-CARDIAC SHUNTS: A.R.C. Dobell, P.P. Reddy, R.E. Cavey, Division CVT Surgery, Montreal Children's Hospital and McGill University, Montreal.

B.3 1545 DUODENAL OBSTRUCTION COMPLICATING SCOLIOSIS SURGERY: N. Grace, S. Youssef, P. Reddy, Department of Paediatric Surgery, McGill University and Montreal Children's Hospital, Montreal.


B.5 1615 CHOLANGIOGRAPHIC STUDIES AND LIVER BIOPSIES IN TWO CASES OF BILIARY ATRESIA: M.S. Sabet, R.F. Kennedy, S. Bridger, The Janeway Child Health Centre, St. John's.

B.6 1630 PORTAL HYPERTENSION IN CHILDREN: G. Beauchamps, H. Blanchard, J.G. Desjardins, P.P. Collin, F.M. Guttman, C. Roy, C. Morin, Department of Surgery and Gastroenterology, Ste Justine Hospital, University of Montreal, Montreal.

B.7 1645 UMILICAL CIRCUMCISION — A NEW TECHNIQUE FOR REPAIR OF A LARGE UMILICAL HERNIA: B. Shandling, Hospital for Sick Children, University of Toronto, Toronto.
THURS. JAN. 22
1400-1715

Canadian Association of Paediatric Surgeons

Room 3
Convention Centre
Annual Scientific Meeting: Session C

Chairman: Dr. J. S. Simpson, Toronto

1400 Guest Lecturer

C.1 Surgical Aspects of Intersex
Dr. D. Pellerin, Hôpital Necker Enfants Malades, Paris, France

Abstract Number

C.2 1445 Surgery of Anal Imperforations at Ste. Justine’s Hospital since 1957: B. Dandurand, J. Boisvert, Department of Surgery and Radiology, Ste. Justine’s Hospital, Montreal.

C.3 1500 Mechanical Parameters of Fecal Continence in 50 Children Operated for Anorectal Malformations: P. Arhan, C. Faverdin, G. Devroede, F. Dubois, L. Coupris, D. Pellerin, Departments of Surgery and Physiology, Centre Hospitalier Universitaire Necker, Paris and Centre Hospitalier Universitaire, Sherbrooke.


1530 Coffee Intermission

1600 Panel Discussion:

Multiple Trauma in Children
Moderator: Dr. J. C. Fallis, Toronto

1) Abdominal Injuries: Dr. Stanley Mercer, Children’s Hospital of Eastern Ontario, Ottawa.

2) Head Injuries: Dr. Bruce Hendrick, The Hospital For Sick Children, Toronto.

3) Chest Injuries: Dr. Gordon M. Karn, Montreal Children’s Hospital, Montreal.
A.1 GUEST LECTURER

TERATOMAS OF THE CHILDREN

DR. D. PELLERIN, Hôpital Necker Enfants Malades, Paris
TESTICULAR SCANNING FOR TESTICULAR TORSION — AN IMPORTANT NEW DIAGNOSTIC AID.

Barry Shandling, David L. Gilday, David C. Hitch
Hospital for Sick Children, University of Toronto, Toronto.

The infant or small boy with a swollen painful testis presents a diagnostic enigma. In small patients testicular torsion can only rarely be distinguished from acute epididymo-orchitis. Until recently surgical exploration was the only accurate means of differentiation.

Unfortunately this meant that some patients without torsion of the testis underwent unnecessary operations. While in others an often disastrous “wait and see” approach was employed.

Since its introduction for adults in 1973 scrotal scanning has allowed a precise evaluation of the perfusion of the scrotal contents and thus has refined the criteria for operation. Our experience with children has been so dramatic that an early report is warranted.

Using the gamma camera with a high resolution collimator images were obtained during the vascular phase using magnetic tape recall. We have been able correctly to make an accurate diagnosis in 90% of nine patients studied. The investigation is safe, rapid and need delay treatment no more than fifteen minutes.
TRAUMATIC RUPTURE OF THE DIAPHRAGM IN CHILDREN.

L. K. Sharma, R. Kennedy, W. D. Heneghan
The Janeway Child Health Centre, St. John’s, Newfoundland.

Traumatic rupture of the diaphragm is a rare entity in children. In a recent analysis of traumatized patients, we were surprised to find six cases. In most cases, severe injury has been a feature and the condition has been associated with high mortality. A high level of clinical and radiological suspicion in Thoraco-abdominal compression injuries will permit earlier recognition and prompt treatment.
LECTURE AND DISCUSSION

EXAMINATION OF THE EYE IN PAEDIATRIC EMERGENCY CIRCUMSTANCES

DR. TREVOR KIRKHAM, Director, Department of Ophthalmology, Montreal Children's Hospital, Montreal.
SEVERE FEEDING PROBLEMS IN CHILDREN WITH INTRACARDIAC SHUNTS.

A. R. C. Dobell, P. P. Reddy, R. E. Cavey
Division CVT Surgery, Montreal Children’s Hospital and McGill University, Montreal.

Failure to thrive is a fairly common consequence of serious congenital cardiac anomalies. The three infants we wish to present did not fit into this mold. Their failure was considered mild and not a likely cause of their severe feeding disorders. All had exhaustive studies to seek another cause of their persistent vomiting and lack of interest in food. Formulas were repeatedly changed and multiple specialists were consulted. One underwent pyloromyotomy without benefit. The pulmonary artery pressures were high normal in these three infants (2 VSD and 1 TAPVD) whose mean weight was 4.6 kgms at 5 months of age, but heart failure was judged to be controlled by medical treatment. Digitalis intoxication was excluded in all.

Each infant responded dramatically to operation with complete cessation of vomiting and arousal of appetite. One with a congenital thyroid disorder remains small but the food intake problem has been relieved. The mechanism for the esophageo-gastric disorder and prompt relief after operation is not understood. Nevertheless, we must recognize that severe feeding disorders may be caused by moderate left to right shunts without pulmonary hypertension.
DUODENAL OBSTRUCTION COMPLICATING SCOLIOSIS SURGERY.

N. Grace, S. Youssef, P. Reddy
Department of Paediatric Surgery, McGill University and Montreal Children’s Hospital, Montreal.

At the Montreal Children’s Hospital in less than 2 years we have treated three cases of duodenal obstruction following major orthopedic procedures for scoliosis. Two were typical of superior mesenteric artery syndrome. Both of these were initially treated with total parenteral nutrition and positioning, one eventually came to laparotomy and complete mobilization of the duodenum in the method described by Burrington. The third had a retroduodenal internal hernia which was symptomatic prior to spinal fusion. The 3rd stage of the duodenum was completely obstructed by Ladd’s bands following the scoliosis surgery and a laparotomy with release of these was necessary. The management of these problems is discussed and their relationship to the “cast syndrome” as it has been described. As many more advanced spinal deformities are being given the benefits of surgical correction, would preoperative gastro-duodenal X-rays draw attention to these potential complications?
HERNIAGRAPHY: 10 YEARS AND 1200 CASES LATER.

Jacques C. Ducharme, Arié L. Bensoussan, Frank M. Guttmann, Robert Bertrand
Département de Chirurgie et de Radiologie, Hôpital Ste-Justine, Montréal.

This radiological method for the diagnosis of anomalies of the inguinal region was initiated at Sainte-Justine Hospital in 1966. It now seems appropriate to evaluate its usefulness. The technique as defined in the early months has remained the same except for dilution of the contrast material. Herniagraphy will reveal a hernia with 97% accuracy, the surgeon 40% and the parents 20%.

The percentage of contralateral hernia is 26%. A processus vaginalis less than 0.5 by 2 cm is not a hernial sac. The incidence of false injection in the abdominal walls, intestines, and bladder has considerably diminished with experience. Dilution of contrast material has resulted in almost complete disappearance of pain, nausea and vomiting.

It is well accepted by the patients and parents: no complaints from parents in 10 years. It does not appear to be more traumatic than an I.V. session. The method is used in France, Switzerland, Germany, Spain, the U.S. and Canada. It has been shown by Detrie, to be extremely useful in adults particularly in crural hernia, and direct hernia. It greatly facilitates diagnosis of a recurrent inguinal hernia. Routine bilateral inguinal exploration is needless surgery 75% of the time.
CHOLANGIOGRAPHIC STUDIES AND LIVER BIOPSIES IN TWO CASES OF BILIARY ATRESIA.

M. S. Sabet, R. F. Kennedy, S. Bridger
The Janeway Child Health Centre, St. John’s, Newfoundland.

Out of our cases of biliary atresia, we present two interesting cases, “a correctable and a non-correctable biliary atresia”.

Whereas, the cholangiograms were reliable in initial diagnoses, they were not helpful in predicting the results obtained in these patients.

The liver biopsy in these cases certainly reflected the disease process more accurately.
PORTAL HYPERTENSION IN CHILDREN.

Gilles Beauchamp, Hervé Blanchard, Jean G. Desjardins, Pierre Paul Collin, Frank M. Guttman, Claude Roy, Claude Morin
Department of Surgery and Gastroenterology, Ste-Justine Hospital, University of Montreal, Montreal.

During the past 16 years, 53 children were seen with portal hypertension at Ste-Justine’s Hospital for Children. Extra-hepatic bloc was found in 29 and intra-hepatic bloc in 24. The average age was 10 years for the first group. A history of umbilical catheterization was noted in 7 patients for exchange transfusion, and in 4 others for septicemia, or primary peritonitis. The major signs were hematemesis, melena, abdominal pain and anaemia. Splenomegaly was present in all patients. In all patients with extra-hepatic block, hepatic function and biopsies were normal. The major problem in these children was oesophageal variceal bleeding, often caused by U.R.I. or aspirin ingestion. The average age for the intra-hepatic bloc group was 5½ years. Here, g.I. hemorrhage and hepatosplenomegaly were found as well as abnormal liver function and biopsy. The frequent regression of symptoms and signs justify conservative management of bleed in extra-hepatic portal hypertension. The prognosis in intra-hepatic portal hypertension is related to the chronic progressive nature of hepatic disease.
UMBILICAL CIRCUMCISION — A NEW TECHNIQUE FOR REPAIR OF A LARGE UMBILICAL HERNIA.

Barry Shandling
Hospital for Sick Children, University of Toronto, Toronto.

Umbilical herniorrhaphy is largely a cosmetic operation. From the patient’s point of view it is exclusively cosmetic. Thus it behoves the surgeon not just to be satisfied with closing the hole in the abdominal wall. The aim of surgical treatment must include restitution of the umbilical cicatrix as closely as possible to what is socially acceptably inconspicuous.

Circumcision of the umbilicus followed by repair with suture of the skin in such a manner as to result in an unobtrusively normal-looking navel is the essence of this technique.

The method will be described and illustrated. It has been used for less than a year but the results are gratifying.
GUEST LECTURER

SURGICAL ASPECTS OF INTERSEX

DR. D. PELLERIN, Hôpital Necker Enfants Malades, Paris, France
CHIRURGIE DES IMPERFORATIONS ANALÉS A L'HOPITAL STE-JUSTINE DEPUIS 1957.

Bruno Dandurand, Jacques Boisvert
Département de chirurgie et de radiologie, Hôpital Ste-Justine, Montréal.

Analyse de 170 cas de malformations anorectales classifiés selon les 27 variétés de la classification internationale résumées en formes hautes (supra levator ani) et en formes basses (trans levator). Les anomalies congénitales associées les plus fréquentes sont les malformations vertébrales (58% des variétés hautes et 25% des variétés basses), les anomalies urinaires (17 cas), et les atrésies de l'oesophage (10 cas). L'évaluation fonctionnelle à long terme révèle que:

1— La continence est normale dans 99% des variétés basses traitées par anoplastie simple (vs transposition anale);
2— La chirurgie correctrice par abdominopérinéale classique donne seulement 50% de bons résultats (variétés hautes); 
3— L'abdomino péritéale modifiée trans levator ani avec triple approche sacro-abdomino-périnéale donne 75% de succès;
4— Les variétés moyennes ont avantage à être traitées par colostomie néonatale puis par abdominopérinéale trans levator ani à l'âge de 1 an comme les hautes;
5— La chirurgie réparatrice des cas ayant un mauvais résultat fonctionnel est possible mais améliore rarement les patients.
MECHANICAL PARAMETERS OF FECAL CONTINENCE IN 50 CHILDREN OPERATED FOR ANORECTAL MALFORMATIONS.

P. Arhan, C. Faverdin, G. Devroede, F. Dubois, L. Coupris, D. Pellerin
Départements de chirurgie et physiologie, CHU Necker, Paris, and CHU, Sherbrooke.

Patients operated for high anorectal malformations are frequently incontinent. The purpose of this work was to corroborate these clinical data by functional exploration of the rectoanal motility. In the 49 investigated subjects, 23 had undergone an abdominoperineal procedure for a high malformation and 7 for a low malformation. 17 had undergone a proctoplasty for a low malformation and 2 were referred after proctoplasty for a high malformation. In each child, length of anal resistance, rectoanal inhibitory reflex, effect of voluntary contraction, anal sensibility, rectal, anal and marginal resting pressure were studied and compared to a group of normal subjects. Eight out of 30 subjects who had undergone an abdominoperineal approach were continent in contrast to 15 out of 19 patients who had undergone a perineoplasty. In the former group the patients did not have a rectoanal inhibitory reflex but showed a "neorectal" motility of "colonic" type. In these patients, incontinence coincided with one or several abnormal mechanical parameters of the anal canal. In the subjects who had undergone a proctoplasty, most parameters were normal. Thus functional abnormalities reflect the anatomical dysgenesis.
WILMS' TUMOUR. ADJUVANT ACTINOMYCIN-D AND VINCristINE: TREATMENT RESULTS AND TOXICITY.

The Princess Margaret Hospital and The Hospital for Sick Children, Toronto.

In an unselected series of 49 children with Wilms' Tumour treated in Toronto during 1969-74 the 5 year relapse free and survival rates were 78% and 81%. During 1963-8 the comparable results were 49% and 70%.

Adjuvant treatment with maintained Actinomycin-D and Vincristine was given to patients in Stages II-IV and this was the chief factor responsible for these improved results.

Seven of 49 patients have died, 4 due to progressive Wilms' Tumour and 3 due to treatment toxicity.
PANEL DISCUSSION:

MULTIPLE TRAUMA IN CHILDREN

MODERATOR: DR. J. C. FALLIS, Toronto

1) ABDOMINAL INJURIES: Dr. Stanley Mercer, Childrens’ Hospital of Eastern Ontario, Ottawa.

2) HEAD INJURIES: Dr. Bruce Hendrick, The Hospital For Sick Children, Toronto.

3) CHEST INJURIES: Dr. Gordon M. Karp, Montreal Children’s Hospital, Montreal.
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<td>Montreal, P.Q.</td>
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