1977 programme

TUESDAY, JANUARY 25

1000-1700 Council: Sheraton Centre, Carlton Room

1900 Informal Buffet: Members and Guests
Hosts: Jim and Jo Simpson,
226 Inglewood Dr., 488-9912.

WEDNESDAY, JANUARY 26

ANNUAL SCIENTIFIC MEETING: HOSP. for SICK CHILDREN

0900-1000 Business Meeting: Members Only
Small Lecture Theatre.

1030 Scientific Session: Large Lecture Theatre.

1230-1400 Luncheon: Nurses' Residence.

1400-1730 Scientific Session: Large Lecture Theatre.

1830 Presidential Reception and Dinner
Sheraton Centre, Essex Room, Black Tie.

THURSDAY, JANUARY 27

JOINT MEETING with the ROYAL COLLEGE of SURGEONS (CAN)
Sheraton Centre, Grand Ballroom East.

1400-1500 Guest Lecturer: F. Douglas Stephens

1500-1700 Scientific Session
The Canadian Association of Paediatric Surgeons was granted its charter in 1967. Its main aim is to improve the surgical care of infants and children in Canada.

There are three main areas in diagnosis, treatment and research which are of special concern to the members.

**Infants Born With Congenital Abnormalities**

Even though the majority of newborn infants who have severe congenital abnormalities can be treated successfully by a surgical operation, often the condition is either not recognized, or if it is diagnosed, the local physician may be unaware of the possibilities for surgical cure. In this situation most of these babies die, or some survive to live a life crippled by their deformity.

**Malignancy in Childhood**

Cancer is the second commonest cause of death in childhood. Now surgical removal of the tumor, combined with x-radiation and chemotherapy provided by an aggressive team utilizing new techniques can achieve a cure in over 50% of these patients.

**Trauma**

Finally, the number one killer of children in North America is accidents. Here again, with modern methods of first aid, transportation, resuscitation, intensive care, and specialized surgical team effort many of these seriously injured children can be saved.

**EDUCATION PROGRAM**

To accomplish an improvement in surgical care for babies and children, the Canadian Association of Paediatric Surgeons has launched an educational program for doctors, nurses and others working in the paediatric health field. To support this program, an educational fund has been established.
programme détaillé 1977

1977 programme schedule
MÉR.
26 JAN.
9h à 12h
l'association canadienne
de chirurgie infantile

HOSPITAL
FOR SICK
CHILDREN
Congrès scientifique annuel

LE PRESIDENT: J. SIMPSON, Toronto

9h REUNION GENERALE ANNUELLE
10h PAUSE-CAFE

10h30 CONFERENCE
DEFORMATIONS ET MALFORMATIONS DU PERINEE
F. DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago
11h DISCUSSION

RESUME


234 11h30 DEFICIENCE EN ACIDES GRAS ESSENTIELS DURANT L'ALIMENTATION PARENTERALE CHEZ LES BEBES: R. Postuma, P. W. B. Pease, R. Watts, S. Taylor, F. A. McCoy, Hôpital Children's, Birmingham et Centre des sciences de la santé (pour enfants), Winnipeg.

12h DISCUSSION
canadian association of paediatric surgeons

HOSPITAL FOR SICK CHILDREN

Annual Scientific Meeting

CHAIRMAN: J. SIMPSON, Toronto

0900 ANNUAL GENERAL MEETING
1000 COFFEE INTERMISSION

1030 GUEST LECTURER

FORMATIONS AND MALFORMATIONS OF PERINEAL DEFORMITIES
F. DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago.

1100 DISCUSSION

ABSTRACT NO.


234 1130 ESSENTIAL FATTY ACID DEFICIENCY DURING PARENTERAL NUTRITION IN INFANTS: R. Postuma, P. W. B. Pease, R. Watts, S. Taylor, F. A. McCoy, Children's Hospital, Birmingham and Health Sciences (Children's) Centre, Winnipeg.


1200 DISCUSSION
MER.
26 JAN.
14h à 17h30
l'association canadienne
de chirurgie infantile

HOSPITAL
FOR SICK
CHILDREN
Congrès scientifique annuel

LE PRESIDENT: P. G. ASHMORE, Vancouver

RESUME

236 14h HERNIE DIAPHRAGMATIQUE CONGENITAUTE ACQUISE: N. E. Wiseman, R. Macpherson, départements de chirurgie et de radiologie, Université du Manitoba, Centre des sciences de la santé (pour enfants), Winnipeg.


239 14h45 L'ACHALASIE DANS LE GROUPE PEDIATRIQUE. EXPERIENCE AU HOSPITAL FOR SICK CHILDREN: M. A. Bleicher, A. G. de la Rocha, B. Shandling, division de chirurgie générale, Hospital for Sick Children, Toronto.

15h15 PAUSE-CAFE

LA CHIRURGIE DE L'ENTESTIN

LE PRESIDENT: H. BEARDMORE, Montréal

RESUME

241 15h45 PSEUDO-MALADIE DE HIRSCHSPRUNG OU PSEUDO-OBSTRUCTION INTESTINALE. SANS CONTESTE UNE ENIGME: S. Kling, département de chirurgie, Université de l'Alberta, Edmonton.

242 16h AGANGLIONOSE COLIQUE TOTALE: S. Venugopal, B. Shandling, division de chirurgie générale, Hospital for Sick Children, Toronto.


244 16h30 CAUSES INUSITEES DU SAINEMENT DE L'ENTESTIN GRELE DURANTES DIX PREMIERES ANNEES DE VIE: D. G. Marshall, Université Western Ontario, département de chirurgie pédiatrique, London.
WED.
JAN. 26
1400-1730

CANADIAN ASSOCIATION
OF PAEDIATRIC SURGEONS

HOSPITAL
FOR SICK
CHILDREN

ANNUAL SCIENTIFIC MEETING

CHAIRMAN: P. G. ASHMORE, Vancouver

ABSTRACT
NO.
236 1400 ACQUIRED CONGENITAL DIAPHRAGMATIC HERNIA: N. E. Wiseman, R. Macpherson, Departments of Surgery and Radiology, The University of Manitoba, Health Sciences (Children's) Centre, Winnipeg.


238 1430 THE VALUE OF CIRCULAR MYOTOMY FOR ESOPHAGEAL ATRESIA: D. Vizas, S. H. Ein, J. S. Simpson, Division of General Surgery, The Hospital for Sick Children, and Department of Surgery, University of Toronto, Toronto.


1515 COFFEE INTERMISSION

INTESTINAL SURGERY
CHAIRMAN: H. BEARDMORE, Montreal

ABSTRACT
NO.
241 1545 PSEUDO HIRSCHSPRUNG'S DISEASE OR PSEUDO INTESTINAL OBSTRUCTION — AN ENIGMA BY ANY NAME: S. Kling, Department of Surgery, University of Alberta, Edmonton.

242 1600 TOTAL COLON AGANGLIONOSIS: S. Venugopal, B. Shandling, Division of General Surgery, The Hospital for Sick Children, Toronto.


244 1630 UNUSUAL CAUSES OF SMALL BOWEL BLEEDING IN THE FIRST DECADE: D. G. Marshall, University of Western Ontario, Department of Pediatric Surgery, London.
JEU.
27 JAN.
14h à 17h
l'association canadienne
de chirurgie infantile

GRANDE SALLE
DE BAL EST
(SHERATON)
Congrès scientifique annuel
(Interprétation simultanée)

LE PRESIDENT: S. KLING, Edmonton

14h CONFERENCE
UNE EXPLICATION DES MALFORMATIONS RENALES RELATIVES
AU FLUX VESICO-URETERAL, AUX URETEROCLES ET AUX
VALVULES URETRALES
F. DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago

RESUME
245 15h MESENCHYMOME MALIN CHEZ LES ENFANTS: S. Dubé, J. C.
Ducharme, G. Berdnikoff, département de chirurgie pédiatrique, Univer-
sité de Montréal, Hôpital Sainte-Justine, Montréal.

246 15h15 TOMOGRAPHIE DE L'ABDOMEN PAR ORDINATEUR CHEZ LES
BEBES ET LES ENFANTS: B. J. Reilly, service de radiologie, Hospital for
Sick Children, Toronto.

15h30 PAUSE-CAFE

LE PRESIDENT: B. SHANDLING, Toronto

247 16h TEMPERATURE DIFFERENTIELLE ENTRE LE SCROTUM ET LE
CANAL INGUINAL CHEZ DES MALADES AVEC TESTICULES NON DES-
CENDUS: B. O'Donnell, Our Ladies Hospital for Sick Children, Crumlin,
Dublin.

248 16h15 LA GREFFE RENALE CHEZ LES ENFANTS — UNE EXPERIENCE
DE DEUX ANS A L'HOPITAL SAINTE-JUSTINE: H. Blanchard, P. Robitaille,

16h30 CLOTURE
THURS. JAN. 27 1400-1700
canadian association of paediatric surgeons

GRAND BALLROOM EAST (SHERATON) Annual Scientific Meeting (Simultaneous interpretation session)

CHAIRMAN: S. KLING, Edmonton

1400 GUEST LECTURER
AN EXPLANATION OF RENAL MALFORMATIONS ASSOCIATED WITH VESICOURETERAL REFLUX URETEROCELES AND CONGENITAL POSTERIOR URETERAL VALVES
F. DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago

ABSTRACT NO.

245 1500 MALIGNANT MESENCHYMOMAS IN CHILDREN: S. Dubé, J. C. Ducharme, G. Berdnikoff, Department of Pediatric Surgery, University of Montreal, Sainte-Justine Hospital, Montreal.

246 1515 COMPUTED TOMOGRAPHY OF THE ABDOMEN IN INFANTS AND CHILDREN: B. J. Reilly, Department of Radiology, The Hospital for Sick Children, Toronto.

1530 COFFEE INTERMISSION

CHAIRMAN: B. SHANDLING, Toronto

247 1600 TEMPERATURE DIFFERENTIALS BETWEEN SCROTUM AND INGUINAL CANAL IN PATIENTS WITH UNDESCENDED TESTIS: B. O'Donnell, Our Ladies Hospital for Sick Children, Crumlin, Dublin.


1630 CLOSING REMARKS
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS

L’ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE

Directors:
- President: Dr. James S. Simpson
- President Elect: Dr. Samuel Kling
- 3rd of three years: Dr. Gordon Karn
- 2nd of three years: Dr. Stanley Mercer
- 1st of three years: Dr. Alec Gillis

Secretary Treasurer:
- Dr. Gordon S. Cameron

Committee Chairmen:
- Nominating: Dr. Colin Ferguson
- Programme: Dr. Graham Fraser
- Local Arrangements: Dr. Barry Shandling
- Membership & Credentials: Dr. Fred DuVal
- Publications: Dr. Donald Marshall
- Health Care Data: Drs. Samuel Kling & William Taylor
- Ethical & Moral Issues: Dr. Frank Guttman
- Education Fund: Dr. Colin Ferguson
- Liaison to the Royal College: Dr. Clinton Stephens
9h  REUNION GENERALE ANNUELLE

CHAIRMAN: J. SIMPSON, Toronto

0900  ANNUAL GENERAL MEETING
1030 GUEST LECTURER
FORMATIONS AND MALFORMATIONS OF PERINEAL
DEFORMITIES
F DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago.
1100 DISCUSSION
233 GASTROSCHISIS AND OMPHALOCELE: GREAT PROGRESS — NEW CONCERN
A. Girard, A. L. Bensoussan, H. Blanchard, F. M. Guttman, P. P. Collin, J. C. Desjardins, Montreal

This is a review of 76 patients with gastroschisis and omphalocele which have been treated at Ste-Justine Hospital from 1954 to 1976.

Two thirds of these infants had omphalocele of which 20% were ruptured, the rest (1/3) presented gastroschisis. Prematurity, and malformation of the gastro-intestinal tract were the most common anomaly noted.

Since the use of silastic bag as proposed by Schuster, the mortality among these patients has considerably decreased. Sluggish intestinal transit has been a major problem in our series.

We intend to discuss this latter problem in detail.
234 ESSENTIAL FATTY ACID DEFICIENCY DURING PARENTERAL NUTRITION IN INFANTS

R. Postuma, P. W. B. Pease, R. Watts, S. Taylor, F. A. McEvoy
Children’s Hospital, Birmingham and University of Birmingham, England

The diagnosis of essential fatty acid deficiency (E.F.A.D.) is established by demonstrating a high serum level of 5, 8, 11, eicosatrienoic acid (20:3ω9), low levels of linoleic (18:2) and arachidonic (20:4) acids and a 20:3ω9/20:4 ratio greater than 0.4.

In this paper, E.F.A.D. is described in an infant with gastroschisis who required parenteral nutrition for 6 months. Serial fatty acid determinations in 3 newborn infants with gastroschisis established that E.F.A.D. developed during the first week of fat-free parenteral nutrition and was corrected with the administration of lipids which contain linoleic acid. E.F.A.D. did not develop in 3 other gastroschisis patients when a source of linoleic acid was included in the parenteral nutrition.

This study shows that infants readily develop E.F.A.D. and that parenteral nutrition in infants should include lipids.
PANCREATITIS AND ITS COMPLICATIONS IN THE YOUNG INFANT: AN UNUSUAL PRESENTATION

S. Z. Rubin, S. H. Ein, W. G. Dammert
The Division of General Surgery, The Hospital for Sick Children, Toronto

Pancreatitis in infants is a relatively rare disease. Within the past 5 years two young infants of 3 months presented with ascites of unknown etiology. The similarity of both in reference to their presentation, complications, treatment and outcome warrants their reporting. Complete workups in both instances revealed no apparent cause of the ascites and both infants had a laparotomy. The findings in the lesser sac in each case were unclear and unsatisfactory to the operating surgeons; a retrogastric duplication was thought to be the pathology in the first patient and a sealed perforation of a lesser curvature gastric ulcer was suspected in the second case. Within a few weeks, progressive formation of a massive upper abdominal pseudocyst (with high amylase values) caused severe respiratory distress and required emergency surgical decompression by external drainage. The first infant failed to thrive in spite of parenteral alimentation and eventually required a partial distal pancreatectomy and Roux-en-Y jejunal hookup, which resulted in complete recovery and continued good health over the last 5 years. The second infant, while being treated with an elemental diet through a nasojejunal feeding tube spontaneously drained her pseudocyst into the upper jejunum, following which the fistula between the pseudocyst and the skin closed. She has since continued to be well. It is therefore interesting to speculate that infants with similar presentations should be suspected of having pancreatitis and appropriately investigated. If exploratory laparotomy is carried out the lesser sac should probably be drained, and postoperative nutrition with an elemental diet via a nasojejunal feeding tube considered.
ACQUIRED CONGENITAL DIAPHRAGMATIC HERNIA

N. E. Wiseman, R. Macpherson
Departments of Surgery and Radiology, The University of Manitoba, Health Sciences (Children's) Centre, Winnipeg

Three cases of congenital diaphragmatic hernia are presented in which the herniation of intestinal viscera is shown to have occurred beyond the first month of life. The clinical features of acquired congenital diaphragmatic hernia will be presented. The significance of this clinical entity is that it supplies direct evidence of the fact that the time of occurrence of visceral herniation is variable in congenital diaphragmatic hernia. It is this time variable which may be the most significant determinant for the presence or absence of pulmonary hypoplasia.
237 PULMONARY SEQUESTRATION IN INFANTS AND CHILDREN

D. A. Gillis, K. Aterman
The Izaak Walton Killam Hospital for Children, Halifax

Pulmonary sequestration is generally accepted as denoting a portion of lung lacking normal bronchial connections and having an aberrant systemic arterial supply. The latter appears to be the only feature common to a spectrum of anatomic and clinical abnormalities included under this term.

A review of our experience with pulmonary sequestration at the Izaak Walton Killam Hospital for Children has been carried out. In addition to the well recognized problem of complicating cystic change and sepsis, the clinical presentations included a mediastinal mass in a neonate, cardiac failure in early infancy and recurrent hemoptysis in a teenager.

Some basic embryologic concepts relating to this group of disorders are reviewed and methods of investigation and management are outlined. Stress is placed on the critical importance of angiography in establishing the diagnosis.

All patients underwent successful surgical resection.
238 THE VALUE OF CIRCULAR MYOTOMY FOR ESOPHAGEAL ATRESIA

D. Vizas, S. H. Ein, J. S. Simpson
The Division of General Surgery, The Hospital for Sick Children, and the Department of Surgery, University of Toronto, Toronto

The joining of widely separated proximal and distal esophageal segments in esophageal atresia remains a challenging problem. Livaditis introduced the operation of circular myotomy as an effective means of bridging such a wide gap. Three babies with esophageal atresia were successfully treated in this manner at the Hospital for Sick Children, Toronto during the first 6 months of 1976. No alterations in blood supply of the upper esophageal pouch were observed, and elongations of at least 1 cm per myotomy were obtained. No unusual postoperative radiographic observations were noted.

Our small clinical experience suggests that circular myotomies aid in reducing long esophageal gaps in some infants with esophageal atresia, thus permitting primary esophageal anastomosis.
239 ACHALASIA IN THE PEDIATRIC AGE GROUP: 
EXPERIENCE AT THE HOSPITAL FOR 
SICK CHILDREN

M. A. Bleicher, A. G. de la Rocha, B. Shandling
Division of General Surgery, The Hospital for Sick Children, 
Toronto

From 1953 to 1976 there were 19 patients seen by mem-
bers of the Division of General Surgery at the Hospital 
for Sick Children. Four of these were not operated upon.

This paper is concerned with the manner of presentation, 
diagnosis, management and results of these children. The 
authors contend that roentgenographic evaluation of the 
patient's oesophagus is mandatory in every patient with a 
history of regurgitation or post-prandial discomfort. Treat-
ment should be surgical and the operation recommended is 
the modified oesophagocardio-myotomy in association with an 
anti-reflux procedure.
240 TRANSTHORACIC, END-TO-END REPAIR OF ESOPHAGEAL ATRESIA: A CRITICAL REVIEW OF 41 CASES

H. O. Nason
The Izaak Walton Killam Hospital for Children, Halifax

The technique of primary repair of esophageal atresia remains a controversial issue. The objective of this review, our experience over 5 years, is to compare our results with those recently reported by others using different surgical approaches.

All of our mortalities occurred in infants included in Waterston's group C. The overall mortality was 17%. Leaks occurred in 5%, recurrent fistulae in 5% and stenosis in 30% of cases. All infants in the series had routine dilatations between the 10th and 14th postoperative day. Stenosis was defined as occurring in any infant requiring more than two dilatations and/or dilatation on subsequent admissions. None of the babies defined as having stenosis required further surgery.

End-to-end repair of esophageal atresia using a transthoracic approach is a safe and effective method comparing favorably with other methods reported.
241 PSEUDO HIRSCHSPRUNG’S DISEASE OR PSEUDO INTESTINAL OBSTRUCTION — AN ENIGMA BY ANY NAME

S. Kling
Department of Surgery, University of Alberta, Edmonton

Since Hirschsprung’s classical report in 1888 many theories have been postulated to explain this symptom complex. In 1940 Swensen, Hlatt, Ehrenpreis and others suggested that the disease is a functional obstruction due to a non-propulsive and spastic segment of aganglionic colon. Recently, increasing evidence suggests that this is at best only a partial explanation.

In this paper 4 cases are described which fit the clinical patterns of (1) Pseudo Hirschsprung’s Disease (a) spastic form (b) atonic form (2) Pseudo intestinal obstruction, and (3) Megaduodenum.

It is suggested that all of these, along with “classic” Hirschsprung’s Disease, are probably part of a syndrome which can be labelled “Intestinal Dysfunction Syndrome”.

Current and personal research is reviewed to suggest that these conditions are probably due to a complex of anatomic and histochemical disorders of the neuromusculature involving the small and large bowel and anal sphincters which are still inadequately understood.

As our knowledge of the physiology of normal bowel function improves, so should our understanding and treatment of these conditions.
242 TOTAL COLON AGANGLIONOSIS

S. Venugopel, B. Shandling
Division of General Surgery, The Hospital for Sick Children, Toronto

Sixteen children with aganglionosis of the entire colon have been treated at the Hospital for Sick Children, Toronto. A review of these cases reveals many features peculiar to this type of Hirschsprung’s disease.

In contrast to the group of children with short segment aganglionosis there was a higher proportion of females affected and more frequent positive family history. Nonspecificity of the symptoms, signs and radiological features is the most remarkable feature. All infants with bowel obstruction with no obvious cause even at laparotomy should be considered to have TCA unless proved otherwise.

In earlier years the diagnosis became obvious only at postmortem examination. Unrelieved intestinal obstruction was the commonest cause of death. However with increasing awareness and a high index of suspicion, earlier diagnosis and successful management has been achieved.

The level of enterostomy should be based on histological confirmation of presence of ganglion cells since macroscopic transition zones could be misleading. Definitive pull-through operations have been done for 6 children with one late death. Swenson, Duhamel, Modified Duhamel (Martin) and Modified Soave techniques have been used. Complications of surgery encountered and follow up results are informative although the numbers of cases are small and duration of follow up short.

With early diagnosis and adequate surgical management outlook for this once formidable condition is promising.
243 EVALUATION OF A RATIONAL APPROACH TO THE TREATMENT OF NECROTIZING ENTEROCOLITIS

S. H. Ein, D. Vizas, F. DaCruz, R. Tarar, B. J. Reilly, K. Pape
The Division of General Surgery, The Hospital for Sick Children, Toronto

Between May 1973 and April 1975 we treated 64 cases of necrotizing enterocolitis. Unless there was a perforation noted when the baby was first seen, all newborns in this series were initially treated non-operatively with nasogastric suction, antibiotics and peripheral intravenous hyperalimentation for 1 week. Six hourly x-rays were obtained until the radiological evidence of the necrotizing enterocolitis disappeared, or until surgical intervention was deemed necessary. Forty-three patients had only non-operative treatment with a survival rate of 82%. Twenty-one infants underwent laparotomy because of perforation and/or deterioration with 48% surviving. The overall survival rate was 71%, and there were 6 late structures (9%). In comparison with our previous series of 45 cases (prior to May 1973) in which small sick babies with necrotizing enterocolitis were denied surgery and large fit babies with this disease were operated on, the present results of therapy are much improved and warrant the continued use of this approach.
244 UNUSUAL CAUSES OF SMALL BOWEL BLEEDING IN THE FIRST DECADE

D. G. Marshall
University of Western Ontario, Department of Pediatric Surgery, London

Small bowel bleeding is not a common problem in children. Even the bleeding Meckel's diverticulum is rare. In small bowel bleeding one has to be aware of unusual possibilities; four such unusual possibilities are reported here.

There was an 8 year old boy (called "dirty-face" by his peers) who showed an anaemia. There was a 7 year old girl with an undoubted retroperitoneal mass but an unexplained anaemia. There was an 8 year old boy with a barium x-ray suggestive of a small bowel intussusception; there was the 7 year old girl with an unexplained iron-deficiency anaemia of 5 years standing. These 4 cases presented clinical conundrums and surgical surprises. One must be prepared for diagnostic difficulties and unexpected revelations in small bowel bleeding in children.
1400 GUEST LECTURER
AN EXPLANATION OF RENAL MALFORMATIONS ASSOCIATED
WITH VESICOURETERAL REFLUX URETERoceLES
AND CONGENITAL POSTERIOR URETERAL VALVES
F. DOUGLAS STEPHENS, Children's Memorial Hospital, Chicago.
We have studied 130 patients with Wilms' tumor over a period of 23 years. It is divided in two periods. The first includes 101 patients treated at different hospitals in Montreal and covers the period from 1950 to 1968. The second period includes 29 patients treated at Sainte-Justine's Hospital between 1969 and 1973. About half of the patients had poor general condition, 1/3 complained of abdominal pain and 1/4 of hematuria. The majority of the patients were 4 years of age or less. It seems that the patients are now referred sooner as suggested by the proportion of stage 1 patients which has increased from 32 to 48% and the proportion of stage 4 which decreased from 15 to 6% over the years.

Although the treatments were not the same in the 3 hospitals that provided the material for the first series and even differed within the same hospital during the 18 years of the study, the cure rate was 40%.

The 29 patients of the second group were treated with a rigid protocol under the supervision of the oncology clinic of Ste-Justine's Hospital and their survival rate is 69%. The fate of the 2 groups of patients will be presented as well as the effect of chemotherapy and radiotherapy on the tumor.

Jacques-Charles Ducharme, M.D.
3175 Ch. Sainte-Catherine
Montreal, Quebec, H3T 1C5
246 COMPUTED TOMOGRAPHY OF THE ABDOMEN IN INFANTS AND CHILDREN

B. J. Reilly
Department of Radiology, The Hospital for Sick Children, Toronto

Four months use of a Delta Scanner has resulted in delineation of neoplastic, obstructive and inflammatory renal diseases, hepatic tumours and other abdominopelvic lesions. Examples and statistics, including false-negatives, will be shown together with some features of normal anatomy. The potential usefulness of the method to detect lesions in the spine and hips during abdominopelvic examination is being explored.

Technical problems encountered include:

— difficulty in recognizing organ margins due to lack of perirenal and other fat;

— artefacts produced by contrast-filled renal calyces and gut peristalsis;

— patient immobilization, particularly during infusion of contrast.

Attempts to diminish these are described.
247 TEMPERATURE DIFFERENTIALS BETWEEN SCROTUM AND INGUINAL CANAL IN PATIENTS WITH UNDESCENDED TESTIS

B. O'Donnell
Our Ladies Hospital for Sick Children, Crumlin, Dublin

Abstract Unavailable at time of printing.
RENAL TRANSPLANTATION IN CHILDREN —
2 YEARS EXPERIENCE AT STE-JUSTINE
HOSPITAL

H. Blanchard, P. Robitaille, F. Guttman, J. Mongeau, Montreal

Renal transplantation in pediatric patients with chronic renal failure CRF is a valuable form of treatment. Incidence of CRF in the pediatric population of Province of Quebec is 2.5 per million. It is calculated that about 7% of all dialysed patients are children. From January 1970 to December 1975, 77 children with CRF were admitted to our center. Age varied from 0 to 17 years. The most common cause of CRF in our series has been urinary tract malformations 36%, chronic glomenuro nephritis 22% and renal malformations 21%. (Mongeau et Robitaille)

Among these patients, 19 had 23 renal transplants. Age at transplant varied from 6 to 18 years. Of these patients, 2 had 2 transplants and 1 had 3 transplants. All the kidneys but one were obtained from cadaver donors. Rejection has been the main complication in our series and was the cause of mortality in 4 patients. 10 patients are living 2 to 25 months with a good functioning kidney. There were no urological complications. There were 2 vascular complications. A major problem in children is vascular access for hemodialysis.
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
EDUCATION FUND

ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE
FOND D'ÉDUCATION
EDUCATION FUND

The Education Fund underwrites the visit of selected distinguished paediatric surgeons from overseas each year to visit and to teach at medical centres in Canada, provides a speaker on Paediatric Surgery at the Meeting of the Canadian Paediatric Society, enables the Association to sponsor a session of scientific papers at the Meeting of the Royal College of Physicians and Surgeons of Canada and supports the Annual Scientific Meeting of the Association. Financing for the Education Fund has been attained from individuals and groups, both medical and non medical, interested in the surgical care of children, and from foundations. It is the intent of the Association to increase the capital funding to a level where the annual interest will support the Education Program.

The Education Fund of the Canadian Association of Paediatric Surgeons is registered with the Federal Government and all contributions are fully tax deductible. The Fund is audited annually.

Donations may be sent to —

Dr. G. S. Cameron
Secretary-Treasurer
Education Fund
Canadian Association of Paediatric Surgeons
Department of Surgery
McMaster University Medical Centre
1200 Main Street West
Hamilton, Ontario  L8S 4J9

The Association and the children it serves are grateful to the following individuals and corporations who are helping to advance the surgical care of infants and children across Canada, through their donations to the Education Fund.
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Des particuliers, des associations appartenant ou non au domaine médical, ainsi que différentes agences philanthropiques s’intéressant au progrès de la chirurgie infantile ont bien voulu contribuer à ce fond.

L’objectif de l’Association est d’accroître le capital à un niveau tel que l’intérêt annuel soit suffisant pour défrayer le coût de ce programme.

Le fond d’éducation est enregistré auprès du Gouvernement Fédéral et toute contribution est déductible d’impôt. L’administration de ce fond est consignée dans un rapport annuel.

Les contributions peuvent être expédiées à —

Dr. G. S. Cameron
Secrétaire-trésorier
Fond Educationnel
Association Canadienne de
Chirurgie Infantile
Département de Chirurgie
Centre Médical de l’Université McMaster
1200 Ouest, Main Street
Hamilton, Ontario L8S 4J9
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