10th Annual Meeting
Réunion Annuelle


Canadian Association of Paediatric Surgeons
l’Association Canadienne de Chirurgie Infantile
1978 PROGRAMME

TUESDAY, JANUARY 24

1000-1600  Council:  Four Seasons, Okanagan Suite
1800-1930  Welcome Reception:  Members and Guests
          Four Seasons, Aspen Room (Cash Bar)

WEDNESDAY, JANUARY 25

ANNUAL SCIENTIFIC MEETING:  VANCOUVER GENERAL HOSPITAL

0900-1000  Business Meeting:  Members Only
          (Inservice Education Bldg., 12th Avenue)
1030       Scientific Session:
1230       Luncheon:  Holiday Inn
1400-1700  Scientific Session:
1900       Presidential Reception and Dinner
          Four Seasons, Gallery & Aspen Rm., Black Tie.

THURSDAY, JANUARY 26

JOINT MEETING with the ROYAL COLLEGE of SURGEONS (CAN)

FOUR SEASONS HOTEL, ARBUTUS ROOM

1400-1500  Guest Lecturer:  Professor J. H. Louw
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.
Canadian Association of Paediatric Surgeons

Presidents

1967 - 1972  Harvey Beardmore,  Montreal
1973 - 1974  Colin Ferguson,  Winnipeg
1975 - 1976  Jim Simpson,  Toronto
1977 -  Sam Kling,  Edmonton

Secretary-Treasurer

1967 - 1973  Barry Shandling,  Toronto
1974 -  Gord Cameron,  Hamilton
programme détaillé

programme schedule

1978
WEDNESDAY, JANUARY 25, 1978

VANCOUVER GENERAL HOSPITAL IN-SERVICE EDUCATION CENTER

CHAIRMAN: SAMUEL KLING, EDMONTON

0900 Business Meeting (Members Only)

1000 Coffee

1030 The Fred G. McLeod Lecture
"TOTAL COLONIC AGANGLIONOSIS"
Professor J.H. Louw, Cape Town, South Africa

1100 Discussion

CHAIRMAN: RICHARD KENNEDY, ST JOHNS

1115 214 LIVER DISEASE IN INFANTS RECEIVING
PARENTERAL NUTRITION. R. Postuma, Winnipeg.

1130 215 THE INCIDENCE AND SIGNIFICANCE OF AGENESIS
OR ATROPHY OF TESTIS. S. Mercer, Ottawa

1145 216 INFANTILE POLYCYSTIC KIDNEY
G. G. Mackie, Montreal

1200 217 A CRITICAL LOOK AT DELAYED INTESTINAL MOTILITY
IN GASTROCHISIS. S.Z. Rubin, D. Martin,
S. H. Ein, Toronto.

1230 Lunch

Speaker: Colin C. Ferguson, Winnipeg
"Paediatric Surgery in Europe"
WEDNESDAY, JANUARY 25, 1978

CHAIRMAN: D.A. GILLIS, HALIFAX

1400 218 TRAUMATIC PSEUDOCYSTS OF THE PANCREAS IN CHILDREN. B. Dahman, C. A. Stephens, Toronto


1430 220 NECROTIZING ENTEROCOLITIS – IN PERSPECTIVE G.C.Fraser, M.R.Pendray, Vancouver


1500 Coffee

1515 CHAIRMAN: M. KLIMAN, VANCOUVER

1515 INFORMAL DISCUSSION ON SPECIAL PROBLEM CASES.

JUVENILE POLYPOSIS COLI: A CASE TREATED WITH ILEOENDORECTAL PULLTHROUGH. G.S.Cameron, G.Y.P.Lau, Hamilton.


CERVICAL(THYROID) TERATOMA IN THE NEONATE. T.G.Hwang(by invitation), N.E.Wiseman, Winnipeg.

SPONTANEOUS UMBILICAL EVISCERATION. H. Chochinov, Winnipeg.


### Thursday, January 26, 1978

**Four Seasons Hotel - Arbutus Room**

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<tr>
<td>1400</td>
<td>Guest Lecturer: &quot;THE SCIENTIFIC METHOD IN SURGERY&quot; Prof. J.H. Louw, Cape Town, S.A.</td>
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<td>1500</td>
<td>STAGING LAPAROTOMY IN HODGKIN'S DISEASE. D.P. Girvan, London.</td>
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<td>1530</td>
<td>Coffee</td>
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<td>1600</td>
<td>INTESTINAL OBSTRUCTION BEYOND THE NEONATAL PERIOD. N.E. Wiseman, Winnipeg.</td>
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<td>1615</td>
<td>RENAL TRAUMA IN CHILDREN. H. Seruca, F.M. Guttmann, Montreal.</td>
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<td>1630</td>
<td>Film: &quot;SURGERY OF THE NEWBORN&quot;. J.S. Simpson, Toronto</td>
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<td>1700</td>
<td>Closing remarks.</td>
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Abstracts
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS

Directors:  President  Dr. Samuel Kling
            Past President  Dr. James S. Simpson
            3rd of three years  Dr. Stanley Mercer
            2nd of three years  Dr. Alec Gillis
            1st of three years  Dr. Pierre-Paul Collin

Secretary Treasurer:  Dr. Gordon S. Cameron

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Membership & Credentials:  Dr. Fred DuVal
Publications:  Dr. Donald Marshall
Health Care Data:  Drs. Alec Gillis & William Taylor
Ethical & Moral Issues:  Dr. Frank Guttman
Education Fund:  Dr. Colin C. Ferguson
Liaison to The Royal College:  Dr. Clinton A. Stephens
Canadian Association of Paediatric Surgeons
L'Association Canadienne de Chirurgie Infantile

Réunion Générale Annuelle
Chairman: S. Kling, Edmonton

0900 Annual General Meeting
THE FRED G. MCLEOD LECTURE

"TOTAL COLONIC AGANGLIONOSIS"

Professor J. H. Louw, Cape Town, S. A.

Jan Hendrik Louw

Mr. Louw is Professor of Surgery and Head of the Department of Surgery, University of Capetown. Recipient of numerous honours and awards for distinguished service to medical science and humanity, Professor Louw was particularly honored in 1975 by the establishment of a Paediatric Surgical Department at the Red Cross War Memorial Children's Hospital, and the endowment of a Chair of Paediatric Surgery by his former Chief and mentor.
Serial liver function test were performed in 51 neonates (15 surgical, 36 non-surgical) during parenteral nutrition for 4-300 days (mean — 30 days). SGOT became abnormally elevated (> 50 I.U.) in 7 out of 12 surgery patients (58%) after 8-52 days (mean — 30 days) of therapy compared to 4 out of 26 non-surgical patients (15%) after 18-40 days (mean — 30 days). The range of maximum SGOT was 60-710 I.U. (mean — 247 I.U.) in surgical infants compared to 101-227 I.U. (mean — 156 I.U.) in non-surgical infants. Progressive direct bilirubinemia (> 0.5 mg/dl) occurred in 10 surgical infants (67%) compared to 17 non-surgical infants (47%) and was more severe in the former. Quantitative plasma amino acid determinations in 9 infants demonstrated a progressive deficiency of branched-chain essential amino acids, particularly valine. Liver biopsy in 5 infants showed cholestasis and portal fibrosis which was marked in 2 infants.

In our experience, progressive liver disease is the major metabolic complication of prolonged parenteral nutrition in infants, especially following surgery. Essential amino acid deficiency, particularly of valine, may be one major cause of this complication.
215 THE INCIDENCE AND SIGNIFICANCE OF
AGENESIS OR ATROPHY OF TESTES

S. Mercer, University of Ottawa, Department of
Surgery, Children's Hospital of Eastern Ontario, Ottawa

Agenesis or atrophy of the testes occurred in 15 of 231
consecutive cases operated upon for undescended testes
(6.4%).

In all cases intravenous pyelogram was carried out. The
only anomaly found in the upper urinary tract was agenesis
of kidney (20%). Difficulties in distinguishing agenesis of
testes from atrophy, indications for abdominal exploration
and its timing, and the place of arteriography and endocrine
studies are discussed.
216 INFANTILE POLYCYSTIC KIDNEY

G.G. Mackie, Department of Urology, Montreal Children’s Hospital, Montreal

This is the most common neonatal abdominal mass. Preoperative diagnosis is essential and easily made by the sequence of IVP, cystogram, renal scan and echogram.

Four such kidneys were excised with specimen and ureter immediately injected with contrast medium, demonstrating continuity of cysts one to another. Pathological analysis revealed these communicating cysts surrounded a small focus of dysplastic renal tissue. Only one ureter showed complete atresia; in the other kidneys, the characteristic narrowed ureteral segment showed only hypoplasia in the area of the ureteropelvic junction before widening into a normal ureter, which argues against an obstructive etiology.

The malformation is better explained as a defect of embryogenesis. The cystic component of the kidney represents the blind bulbous end of the ureteric bud stimulated by the small mass of renal tissue encountered by the bud. The defect of vasculature of these kidneys and ureters adjacent to the ureteropelvic junction represent failure of continued stimulation of vasculature by the small amount of renal tissue.

The four cases will be presented with X Rays and Pathology. The embryological defect will be proposed diagrammatically in each case.
217 A CRITICAL LOOK AT DELAYED INTESTINAL MOTILITY IN GASTROSCISIS

S.Z. Rubin, D. Martin, S.H. Ein,
The Hospital for Sick Children, Toronto

The motility of the gastrointestinal tract after the accepted management of gastroschisis using a silon pouch and gradually reducing the herniated intestines is compared with the intestinal motility after primary reduction and closure of the defect.

Since 1970, 45 children with gastroschisis have been treated at The Hospital for Sick Children. Twenty-seven were treated using a silon pouch. Eleven died with an average post-operative survival of 17 weeks; not one had bowel motility allowing oral feedings. The average post-operative period among the 16 survivors after which they were able to take oral feedings was 10 weeks.

Eighteen children were treated by forceful stretching of the abdominal cavity and primary replacement of the eviscerated intestines and closure of the defect. Two died in the early post-operative period of conditions unrelated to the gastroschisis or the procedure. The average post-operative period prior to full oral intake was only four weeks.

A detailed look at the radiological findings indicate the "typical" post-operative dilated loops with fluid levels in the silon treated patients. In the second group of 18 patients, only 2 patients showed dilated loops and fluid levels.

Our findings indicate the decided advantage of primary reduction and closure in the treatment of gastroschisis.
TRAUMATIC PSEUDOCYSTS OF THE PANCREAS IN CHILDREN

B. Dahman, C.A. Stephens, University of Toronto,
Division of General Surgery, Hospital
for Sick Children, Toronto

A retrospective study of 6 children treated for traumatic pseudocyst of the pancreas from 1960 to 1976. On admission to this hospital all patients complained of abdominal pain; 3 were acutely ill. There was a palpable abdominal mass on admission in only 2. Abdominal tenderness, distention and decreased bowel sounds were present in most cases. The admission WBC ranged from 6,100 — 31,600, Hb from 9.6 — 14.3. Amylase values were from 122 — 1226. Bilirubin, S.G.O.T., alkaline phosphatase and serum calcium were all within normal limits. The interval between the time of injury and the recognition of a pseudocyst varied from 9 to 40 days.

Initial treatment consisted of I.V. fluids and nasogastric decompression. Patients later in the series received I.V. alimentation pre and postoperatively. Two patients received elemental feedings via a nasogastric tube placed in the jejunum fluoroscopically postoperatively. Five of the 6 patients required surgical interference. This consisted of external drainage in three and cystgastrostomy in 1. The fifth had 2 operations for internal drainage and both failed. Finally a subtotal pancreatectomy was successful. The six patients all survived.
ANO-RECTAL MANOMETRY IN PREMATURE INFANTS

S. Kling, K.L. Bowes, Department of Surgery,
University of Alberta and University of
Alberta Hospital, Edmonton

In an attempt to establish normal baselines, ano-rectal manometric testing was performed on 28 premature infants varying in weight from 1,000 to 2,700 gms.

Using a sophisticated technique, the following parameters were studied — (1) Resting rectal pressure, (2) Resting sphincter pressure, (3) Frequency of sphincter contractions, (4) Lag between distension of rectum and relaxation of sphincter complex, (5) Lag between the release of distension and recovery of sphincter tone, (6) Residual gradient of sphincter to rectal pressure during relaxation of sphincter.

The results are as follows: (1) Rectal pressure varied from 5-15 cms. of water (mean 11.7 ± 2.3). (2) Sphincter pressure varied from 10-120 cms. (mean 47.54 ± 4.0). (3) Frequency of contractions of the sphincter complex varied from 6-12.6/min. (mean 9.1 ± 0.4). (4) A relaxation response of the anal sphincter complex was observed in all but one infant. (5) Lag between the onset of rectal distension and the appearance of sphincter relaxation was 1.8 ± 0.15 secs. (6) During relaxation the sphincter pressure fell to 10.7 ± 1.15 cms. so the rectal/sphincter gradient was less than 2.0 cms. of water. (7) Lag before return of the sphincter to resting pressure was 2.0 ± 0.2 secs.

Based on this study it is our conclusion that prematurity and low birth weight per se, do not appear to prevent a normal ano-rectal relaxation reflex.
NECROTISING ENTEROCOLITIS — IN PERSPECTIVE

G.C. Fraser, M.R. Pendray, Divisions of Paediatric Surgery and Neonatology, University of British Columbia, Vancouver General Hospital, Vancouver

Since the description of this entity in 1963 the pendulum of surgical treatment has swung from early aggressive intervention to a more calculated and measured approach. This paper will describe the five year experience of treatment of these patients in this centre, with particular reference to: I. The criteria of diagnosis. II. The medical management with special reference to total intravenous feeding. III. The current role of the surgeon. IV. The results of our treatment of subsequent complications e.g., stricture formation.
221 END TO SIDE PORTO-CAVAL SHUNT IN HYPERLIPOPROTEINAEMIA

H. Blanchard, J. Letarte, A. Ouimet, A. Bensoussan, P.P. Collin, J. Desjardins, F. Guttman, Montreal

A 10 year old girl with homozygous Type II hyperlipoproteinaemia refractory to medical treatment and effort myocardial ischemia, had significant improvement in her serum lipid under parenteral alimentation.

After this trial, end to side portocaval shunt caused: — reduction of serum cholesterol — low density lipids — regression of xanthomatos lesions of skin and tendons. The abnormal E.K.G. improved (data will be presented).

End to side porto-caval shunt seems to represent a hope for young patients suffering from this fatal familial disease, who do not respond to medical treatment.

This study covers three years follow-up.
STAGING LAPAROTOMY IN HODGKIN'S DISEASE

D.P. Girvan, University of Western Ontario,
Division of Pediatric Surgery, London

Laparotomy for the staging of Hodgkin's disease has been controversial because of its questionable benefit over non-surgical staging methods. The recent concern of splenectomy and subsequent overwhelming infection has added to this debate.

We have reviewed our experience with 34 cases of Hodgkin's disease varying in age from 6 to 18. Seventeen of these patients underwent staging laparotomy following standard non-operative staging methods and we have a followup period of 2 to 7 years. Seven of these patients had their stage of disease changed as a result of the laparotomy findings. Complications have involved 1 death due to sepsis and 2 patients with subacute bowel obstruction not requiring re-operation.

The role of the spleen in preventing infections will be discussed as well as methods to reduce the possibility of this serious complication.

We feel that staging laparotomy in young people is a valuable diagnostic procedure in determining their subsequent therapy.
223 THYROIDECTOMIE CHEZ L’ENFANT:
EXPERIENCE DE 20 ANS A L’HOPITAL
STE-JUSTINE RESULTATS DU TRAITEMENT
DE L’HYPERTHYROIDIE

S. Yazbeck, J. Guitar, J.G. Desjardins, G. Leboeuf,
H. Blanchard, A.L. Bensoussan, P.P. Collin, Montréal

De 1957 à 1976, 106 patients ont subi une thyroïdectomie à
l’Hôpital Ste-Justine pour les enfants, à Montréal.

Une analyse globale de cette série est présentée ainsi
qu’une analyse détaillée des résultats du traitement de
l’Hyperthyroidie chez l’enfant, 40 patients.

Environ 43% des hyperthyroidies traitées médicamenteusement ont
dû subir un traitement chirurgical. L’indication opératoire la
plus fréquente est l’échec du traitement médical, suivie
par le manque de coopération du patient, rechutes après
premier traitement, réaction au PTU et exophtalmie pro-
gressive.

Les complications post-opératoires à court terme incluent
un œdème trachéal ainsi qu’une hypoparathyroidie transi-
toire. Aucune complication sérieuse ne s’est présentée dans
cette série: section de recurrent laryngé, hémorragie ou
hypoparathyroidie permanente.

Les complications à long terme sont présentées et dis-
cutées.
224 INTESTINAL OBSTRUCTION BEYOND THE NEONATAL PERIOD

N.E. Wiseman, University of Manitoba, Department of Surgery, Health Sciences Children's Centre, Winnipeg

Over a ten-year period (Jan. 1967 — Jan. 1977) at the Children's Centre in Winnipeg, 50 children have been operated upon beyond the first month of life with a diagnosis of intestinal obstruction. In 33 of these children bowel obstruction was due to adhesions resulting from previous surgery. Among this group of patients, one-third had their previous surgery in the neonatal period and two-thirds were operated upon beyond the neonatal period. In patients operated upon in the neonatal period late adhesive obstruction appears to occur most frequently in association with malrotation. In a second group of 17 patients intestinal obstruction was secondary to a congenital abnormality (congenital band, Meckel's diverticulum, malrotation). These two groups of patients are compared with respect to their age distribution, radiologic features, and mechanism of obstruction. All patients had successful surgical treatment for their intestinal obstruction and there was no mortality within this group.
225 RENAL TRAUMA IN CHILDREN

H. Seruca, F.M. Guttman, Department of Surgery,
Ste. Justine Hospital, University of Montreal,
Montreal

Renal trauma is a frequent injury in children. In order to have an intense follow-up, we reviewed those patients admitted only from 1970-76. There were 71 patients — 45 boys (63.4%) and 26 girls (36.6%). Ages varied from 2-15 years, with a mean age of 6.5. While 30 patients were victims of motor vehicle accidents, and bicycle and long distance falls accounted for 14.1% and 16.9% respectively, it was surprising to find 10 patients (14.1%) with minor trauma such as falling off a low stool. Serious injuries were present in 13 patients, while the rest (81.7%) were simple uncomplicated contusions. One patient died with massive renal, hepatic and pulmonary lacerations. Another, who had an avulsion injury to the renal pedicle, survived the injury; "bench surgery", and reimplantation. This patient was previously reported as a world "first" (Guttman et. al.). A total of 11 patients underwent surgery. Of the patients with adequate follow-up to date, (51), one had chronic pyelonephritis which cleared up with treatment, and two had significant renal atrophy.
FOND D'ÉDUCATION

Le fond d'éducation permet d'inviter chaque année d'éminents chirurgiens pédiatiques étrangers pour enseigner dans différents centres médicaux du Canada. Il permet également à notre Association de déléguer un conférencier en chirurgie pédiatrique lors de la réunion de la Société Canadienne de Pédiatrie. Il rend possible une participation élargie de notre Association au programme scientifique du Congrès Annual du Collège Royal des Médecins et Chirurgiens du Canada. Il nous aide enfin à défrayer le coût de la réunion annuelle de l'Association Canadienne de Chirurgie Infantile.

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
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.

Mr. & Mrs. Phillip L. Ashdown
Mrs. Ralph Blackmore
The Children's Hosp. of Winnipeg Research Foundation
Children's Hospital of Eastern Ontario
Messrs Arnold & Charles Hartwell
Lepage's Ltd.
Mr. & Mrs. R. MacLennan
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Mrs. Edward York
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
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Canadian Association of Paediatric Surgeons
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<th>Name</th>
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