11th Annual Meeting
Réunion Annuelle

Montreal,
February 5 - 9, 1979.

Canadian Association of Paediatric Surgeons
l’Association Canadienne de Chirurgie Infantile
programme détaillé

programme schedule

1979
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.
C.A.P.S. SOCIAL ACTIVITIES
CHATEAU CHAMPLAIN

MONDAY, FEBRUARY 5, 1979

Welcoming Reception
Salon de L'Habitation
6:30 p.m.-8:00 p.m.

TUESDAY, FEBRUARY 6, 1979

Ladies Tour of Montreal
9:30 a.m.-4:00 p.m.
Breakfast- Salon Etudes Champlain- 8:30 a.m.
Lunch "Les Filles du Roy"-12:00 p.m.

WEDNESDAY, FEBRUARY 7, 1979

Annual Banquet
Salon Viger A B C
7:00 p.m.

PROGRAMME SOCIALE

Lundi, 5 fevrier,1979

Reception d'accueil
Salon de l'habitation
18:30 h-20:00 h

Mardi, 6 fevrier, 1979

Programme special pour les dames
Journée complète à la découverte de Montréal
9:30 h-16:00 h
Petit déjeuner, Salon Etudes Champlain- 8:30 h.
Déjeuner- "Filles du Roy"- 12:00 h

Mercredi, 7 fevrier, 1979

Banquet Annuel
Salon Viger A B C
19:00 h
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
L'ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE

PRESIDENTS
1967-1972  Harvey Beardmore, Montreal
1973-1974  Colin Ferguson, Winnipeg
1975-1976  Jim Simpson, Toronto
1977-1978  Sam Kling, Edmonton

SECRETARY-TREASURER
1967-1973  Barry Shandling, Toronto
1974-1978  Gordon Cameron, Hamilton
1978-      Frank M. Guttman, Montreal
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
L'ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE

DIRECTORS:

President:

President-Elect:

Past President:

3rd of Three Years:

2nd of Three Years:

1st of Three Years:

Secretary Treasurer:

COMMITTEE CHAIRMEN:

Nominating:

Programme:

Local Arrangements:

Membership & Credentials:

Publications:

Health Care Data:

Ethical & Moral Issues:

Education Fund:

Liaison to the Royal College:

Archivist:

Dr. Samuel Kling
Dr. Pierre-Paul Collin
Dr. James S. Simpson
Dr. Alec Gillis
Dr. Phil Ashmore
Dr. Clinton Stephens
Dr. Frank M. Guttman

DR. JAMES SIMPSON

Dr. Pierre-Paul Collin
Dr. Pierre-Paul Collin
Dr. Jean Desjardins
Dr. Gordon Karn
Dr. Alex Juckes
Dr. David Girvan
Dr. William Taylor
Dr. Frank Guttman
Dr. Colin C. Ferguson
Dr. Clinton A. Stephens
Dr. Barry Shandling
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
L'ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE

February 6, 1979- Montreal Children's Hospital
REUNION GENERALE ANNUELLE
Chairman: Samuel Kling, Edmonton
0900 ANNUAL GENERAL MEETING
CANADIAN ASSOCIATION OF PEDIATRIC SURGEONS

Tuesday, February 6th, 1979

MONTREAL CHILDREN'S HOSPITAL

Chairman: The President, Samuel Kling, Edmonton.

9h00 Annual Business Meeting.

10h00 Coffee.

10h30 The Fred McLeod Lecture
     Congenital Megacolon
     O. Swenson, Miami, Florida.

11h00 Discussion of Problem Cases Related to Megacolon.

Chairman: H. Owen, Montreal.

Megacolon in Eskimos
H. Beardmore, Montreal.

Total Colonic Aganglionosis and the Lester Martin-Duhamel
Procedure - Long term results.
J. C. Ducharme, Montreal.

Megacystis, Microcolon and Hypoperistaltism. Pathophysiology.
F. M. Guttman, J. Richardson, Montreal.

The Short Segment Megacolon.
B. Shandling, Toronto.

12h15 Lunch.

Chairman: Angus W. Juckes, Regina.

Informal Discussion of Particular Cases in Pediatric
Surgery.

14h00 Diverticulitis of the Appendix and Periappendicitis.
A New Syndrome in Children with Cystic Fibrosis.
Departments of Surgery, Paediatrics & Pathology
The Montreal Childrens Hospital
Montreal, Québec.

14h15 Le Ganglioneuroblastome et les V.I.P.
P. P. Collin, M. Schmitt, A. L. Bensoussan, H. Blanchard,
J. G. Desjardins.
Department of Surgery, Ste-Justine Hospital,
Montreal, Quebec
CANADIAN ASSOCIATION OF PEDIATRIC SURGEONS

Tuesday, February 6th, 1979

MONTREAL CHILDREN'S HOSPITAL

14h30 Spontaneous Correction of Esophageal Atresia: A case report.
D. P. Girvan.
Division of Pediatric Surgery, University of Western Ontario and Victoria Hospital, London, Ontario.

14h45 Case Report: Large Intrathoracic Papillary Operable Mass.
N. E. Wiseman.
University of Manitoba, Section of Pediatric General and Cardiothoracic Surgery, Children's Centre, Winnipeg.

15h00 The Pubo Rectalis Sling. A new angle.

15h15 Extraordinary Hyperbilirubinemia in a Neonate with Idiopathic Hypertrophic Pyloric Stenosis.
M. A. Bleicher, M. Reiner; S. Rapaport, N. Track.
The Mount Sinai Hospital & Mount Sinai School of Medicine, N.Y.C.; City Hospital Center at Elmhurst, New York; University of Toronto, Toronto, Ontario. Proposed by: B. Shandling Toronto, Ontario.

15h30 Intestinal Lymphangectasia: Surgical Intervention: A case report.
Parsons, H. G. and Pencharz, P. B.
Department of Paediatrics, McGill University, Montreal, Quebec.

15h45 Coffee.

Chairman: David P. Girvan, London.

16h00 Distribution of Pediatric Surgery in Canada.
W. H. Taylor, Don Mills.
CANADIAN ASSOCIATION OF PEDIATRIC SURGEONS

Thursday, February 8th, 1979

CHATEAU CHAMPLAIN

Chairman: Hervé Blanchard, Montreal.

8h30 Prognostic Factors in Omphalocele and Gastrochisis.

8h45 Nutritional Therapy in Experimental Chylothorax.
R. Postuma, H. Kronhardt, C. C. Ferguson.
University of Manitoba, Section of Pediatric General and Cardiothoracic Surgery, Children's Centre, Winnipeg.

9h00 The Kasai Operation (Hepatopetal-Enterostomy) for Biliary Atresia - Experience with 19 cases.
R. Mustard, B. Shandling.
Department of Surgery, The Hospital for Sick Children, Toronto.

9h15 Factors Influencing Success with Hydrostatic reduction of Ileocolic Intussusception.
A. Thoma, G. Y. P. Lau, D. Rogers, G. S. Cameron.
McMaster University Department of Surgery, St. Joseph's Hospital, Hamilton.

9h30 Habilitation of Patients with Severe Facial Deformities by Corrective Cranio-Orbital Surgery.
Mutaz B. Habal and Jack E. Maniscalco.
USF College of Medicine, Tampa, Florida.


9h45 Rhabdomyosarcoma in Children.
M. Duhaime, J. M. Pagé.
Dept. of Surgery, (Orthopedic), Ste-Justine Hospital, Montréal.

10h00 Status of Lung Function at follow-up in patients with repaired Congenital Diaphragmatic Hernia.
N. E. Wiseman, L. Rosenfield, R. Pagtakhan.
University of Manitoba, Section of Pediatric General and Cardiothoracic Surgery, Children's Centre, Winnipeg.

10h15 Bronchial Compression Syndromes in Infants.
P. G. Ashmore.
Division of Pediatric Surgery, Vancouver General Hospital, Vancouver, B.C. and University of British Columbia, Vancouver, B.C.
CANADIAN ASSOCIATION OF PEDIATRIC SURGEONS

Thursday, February 8th, 1979

CHATEAU CHAMPLAIN

10h30  Endodermal Sinus (Yolk Sac) Tumors in Infants and
       Children.
       A. W. Juckes, M. M. Fraser, D. Dexter.
       Departments of Surgery and Pathology, University of
       Saskatchewan/Regina, Pasqua and Regina General
       Hospitals, Regina.

10h45  L'Hemobilie: Cette méconnue.
       H. Blanchard, Q. N. Ho, A. L. Bensoussan, P. P. Collin,
       J. G. Desjardins.
       Département de Chirurgie, Hôpital Sainte-Justine,
       Montréal, Québec.

11h00  Coffee.

Chairman: R. Cloutier, Québec.

14h00  Panel Discussion on Gastro-oesophageal Reflux.

       The Radiologist Views.
       W. A. Cumming, Toronto.

       The Gastroenterologist Views.
       M. Sainte-Marie, Québec.

       When is Surgery needed.
       A. L. Bensoussan, Montréal.

       The Toronto Hospital for Sick Children Experience.
       B. Shandling.

Chairman: P. P. Collin, Montréal.

15h30  Guest Lecture.

       Specialization. What it Holds for the Future of Medicine.
       O. Swenson, Miami.
Abstracts
THE FRED G. MCLEOD LECTURE

CONGENITAL MEGACOLON

Dr. Orvar Swenson, Miami, Florida

Dr. Orvar Swenson, our distinguished guest, was born in Sweden. He is a graduate of Harvard Medical School. After training in Boston, he became Chief of Surgery at the Boston Floating Hospital of Infants and Children from 1950-1960. He then moved to Chicago to become Chief of Surgery of the Children's Memorial Hospital and Professor of Surgery at Northwestern University Medical School. He is now a retired sailor in Rockport, Maine. Dr. Swenson has been Chairman of the Section of Surgery, American Academy of Pediatrics, Chairman of the Advisory Council of Pediatric Surgeons of the American College of Surgeons and President of the American Pediatric Surgical Association. He has been visiting professor in many centres throughout the world and the recipient of many distinguished awards and degrees. His pioneer work in Hirschsprung's Disease, as well as many other innovations in pediatric surgery, give him a permanent place in the annals of modern pediatric surgery.
DIVERTICULITIS OF THE APPENDIX AND PERIAPEPENDICULITIS. A NEW SYNDROME IN CHILDREN WITH CYSTIC FIBROSIS

G. Gary Mackie, T. A. Seemayer, M. B. Wise, H. F. Owen,
Departments of Surgery, Paediatrics & Pathology, The Montreal Children’s Hospital, Montreal

Appendicitis is a rare complication in children with cystic fibrosis. More commonly, their pains are associated with bowel obstruction due to meconium ileus equivalent. The rarity of appendicitis in Cystic Fibrosis may be due to the appendiceal lumen being distended and completely filled with inspissated stool.

A recent case at our hospital presented with characteristic appendicitis symptoms and was found to have a periaappendicitis. Review of our series of patients with Cystic Fibrosis revealed seven patients who had their appendices removed. Only four had appendiceal inflammation. Three of these had pseudodiverticular protrusions into the appendiceal mesentery with subsequent rupture and periaappendicitis.

This type of appendiceal involvement had not been previously reported. It appear that this is the common mechanism causing appendiceal inflammation in children with Cystic Fibrosis, and is likely due to complete filling of the appendiceal lumen with gradual diverticular formation. It is important that clinicians be aware of the syndrome.

LE GANGLIONEUROBLASTOME ET LES V.I.P.

P. P. Collin, M. Schmitt, A. Bensoussan, H. Blanchard, J. G. Desjardins, Montréal

Une diarrhée profuse avec hypokalémie associée à la présence d’une tumeur neurogène consitue un tableau clinique rare mais bien catalogué. Au delà de 30 cas ont été rapportés dans la littérature médicale depuis 1962, mais tous sauf un, étaient des adultes. Les auteurs rapportent le cas d’un enfant de 11 mois, porteur d’un ganglioneuroblastome cervical qui a présenté un tel syndrome. Ils discutent les mécanismes physiologiques probables de cette entité clinique.
212 SPONTANEOUS CORRECTION OF ESOPHAGEAL ATRESIA: A CASE REPORT

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

A female infant, weighing 2,860 grams, presented with
polyhydramnios at birth and was diagnosed as having esophageal
atresia and tracheo-esophageal fistula. A right thoracotomy at 12
hours of age revealed a long gap esophageal atresia and malrot-
tation of the heart. The fistula was divided and oversewn but the ends
of the esophagus could not be approximated and were left for a
second-look operation at two months of age. At two weeks of age
the gastrostomy formula feeds appeared in the upper pouch suc-
tion catheter.

A fistula tract was identified and eventually strung at
esophagoscopy and dilatation begun. A long period of dilatations
ensued with major difficulties in teaching this child to take oral
feeds and in obtaining adequate weight gain. At 18 months the child
appears to be progressing satisfactorily.

This is the first known reported case of this phenomenon and the
technical difficulties, feeding, nutritional, nursing and familial
problems will be discussed.

213 CASE REPORT: LARGE INTRATHORACIC PAPILLARY OPERABLE MASS

N. E. Wiseman, University of Manitoba,
Section of Pediatric General and Cardiothoracic Surgery,
Children's Centre, Winnipeg

A healthy appearing 10-month-old infant female presented with a
1-week history of cough. Examination revealed a dull right
hemithorax with absent breath sounds and mediastinal shift to the
left side. A fullness was noted in the right upper abdomen. Chest
x-ray revealed a partially opaque right hemithorax with a solid mass
(sonogram) causing inferior displacement of the diaphragm, liver
(nuclide scan) and right kidney (IVP). The right lung was displaced
cephalad (angiogram) and there were several large intercostal
vessels noted. At thoracotomy a large tumor filling the entire right
hemithorax was resected. The postoperative course was unevent-
ful. The gross and microscopic findings and the final diagnosis will
be presented.
THE PUBO RECTALIS SLING. A NEW ANGLE

P. P. Collin, S. Yasbeck, A. Bensoussan, H. Blanchard,
J. G. Desjardins, Département de chirurgie,
Hôpital Sainte-Justine, Montréal

Description of a new approach to the pubo-rectalis sling in cases of supra-levator ani imperforation. Discussion of the technical aspects and the clinical results.

EXTRAORDINARY HYPERBILIRUBINEMIA IN A NEONATE WITH IDIOPATHIC HYPTERTROPHIC PYLORIC STENOSIS

M. A. Bleicher*, M. Reiner*, S. Rapaport**,
N. Track***, *The Mount Sinai Hospital & Mount Sinai School of Medicine, N.Y.C.; **City Hospital Center at Elmhurst, New York; ***University of Toronto, Toronto
Proposed by: B. Shandler, Toronto

The incidence of hyperbilirubinemia occurring in infants with idiopathic hypertrophic pyloric stenosis (IHPS) ranges between 1.9 and 17.0%. One half of the jaundiced infants with pyloric stenosis have an unconjugated hyperbilirubinemia between 5 and 10 mg %. Marked elevations of total bilirubin with preponderant indirect fraction have previously been reported. Our case describes an extraordinarily elevated total bilirubin level (50.0 mg %) with indirect fraction (46.1 mg %) which reverted to normal (total: 0.9 mg %; indirect: 0.7 mg %) seven weeks after Fredet-Ramstedt pyloromyotomy for IHPS. Although the etiology of jaundice occurring in patients with IHPS remains uncertain, theories implicating inhibition of the glucuronyl transferase system have been proposed. Infants with IHPS have a documented hypergastrinemia. An hypothesis is offered, illustrated by this case, to explain the inhibition of the glucuronyl transferase system with resultant hyperbilirubinemia by the hypergastrinemia of idiopathic hypertrophic pyloric stenosis.
216 INTESTINAL LYMPHANGECTASIA: SURGICAL INTERVENTION: A CASE REPORT

H. G. Parsons, and P. B. Pencharz.
Department of Paediatrics, McGill University, Montreal, Quebec

K.R., a 6 year old boy, underwent an elective resection of 40 cm. jejunum 10 months ago because of an exudative enteropathy resulting from primary intestinal lymphangectasia.

The diagnosis of intestinal lymphangectasia with exudative enteropathy was established histopathologically and by the loss of 4.2% of C\(^\text{51}\) chloride tagged albumin in the gut in 4 days (normal<2%). His clinical course is summarized in the following table:

<table>
<thead>
<tr>
<th>AGE</th>
<th>T.P.</th>
<th>ALB.</th>
<th>COURSE AND TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 mo.</td>
<td>5.6</td>
<td>2.95</td>
<td>preliminary investigation</td>
</tr>
<tr>
<td>38 mo.</td>
<td>3.4</td>
<td>1.39</td>
<td>diarrhoea, oedema, hypoproteinaemia</td>
</tr>
<tr>
<td>39 mo.</td>
<td>3.5</td>
<td>1.95</td>
<td>colonic polypectomy</td>
</tr>
<tr>
<td>57 mo.</td>
<td>3.8</td>
<td>1.82</td>
<td>anorexia, emesis, diarrhoea, abdominal cramps continued</td>
</tr>
<tr>
<td>63 mo.</td>
<td>4.8</td>
<td>2.9</td>
<td>11 days post-jejunectomy</td>
</tr>
<tr>
<td>73 mo.</td>
<td>3.5</td>
<td>2.1</td>
<td>10 months post-intestinal resection, clinically well</td>
</tr>
</tbody>
</table>

Prior to surgery his condition was very unstable necessitating repeated hospital admission and requiring TPN on five occasions, and the continuous use of diuretics. Because of deteriorating clinical state and inadequate growth (5 cm. in 2 years) elective surgical intestinal resection was undertaken. Since intestinal resection he has been continued on his elemental amino acid diet supplemented with high protein and medium chain triglycerides without diuretics. He has been clinically well and grown 6 cm.
PROGNOSTIC FACTORS IN OMPhALOCELE AND GASTROSCHEMSIS

G. Stringel, R. M. Filler, The Department of Surgery, The Hospital For Sick Children, Toronto

All cases of omphalocle and gastroschisis seen in the last 10 years were analyzed to determine factors associated with mortality. Twenty of 26 deaths in 79 infants with omphalocle were due to severe congenital defects. The mortality in infants in whom birth weight was below 2500g was 65% as compared to 14% in those larger. The mortality did not appear to be related to the viscera exposed or the diameter of defect. In 18 of the 26 deaths surgical repair could not be performed because of the infants’ critical condition. Eight of 56 infants treated surgically died. One due to RDS and seven the result of severe congenital anomalies. Total Parenteral Nutrition (TPN) was needed in only 10% of cases.

Twelve of 44 neonates with gastroschisis died. The size of the defect, viscera exposed, incidence of low birth weight, and presence of other congenital anomalies did not appear to affect the final outcome. TPN was employed in 75% of cases. Median duration of TPN was 25 days in the survivors and in those who died. All infants were treated surgically. The highest survival (90%) was seen in the 18 infants whose abdominal wall was closed without the use of prosthetic materials. Only 55% survived when a silon pouch was used for closure.
NUTRITIONAL THERAPY IN EXPERIMENTAL CHYLOTHORAX

R. Postuma, H. Kronhardt, C. C. Ferguson.
University of Manitoba, Section of Pediatric
General and Cardiothoracic Surgery, Children's Centre,
Winnipeg

Persistent chylothorax is a serious problem in infants and children. Present management includes oral medium-chain triglyceride diet (MCT) and closed chest drainage. Reportedly, the MCT reduces chyle formation and promotes thoracic duct closure but, in our clinical experience, the treatment is frequently unsuccessful.

To determine the effect of nutritional therapy on chyle flow and composition, the thoracic duct was divided and closed chest drainage established in anesthetized dogs. Four dogs each received regular chow (controls) or MCT diet. Although the MCT dogs drained significantly less chyle than the control group (118 ± 109 ml/day vs. 183 ± 168 ml/day; p < 0.01), the fistula remained open longer in the MCT group (18 vs. 14 days) and failed to close in 2 MCT and in 1 control dog; the latter 3 all died. The concentrations of cholesterol and protein in the chyle and the net weight loss were significantly higher in the MCT group.

Since the MCT group consumed significantly less nutrients than the controls, another 4 dogs were force-fed with MCT. There were no significant differences in the closure rates, daily chyle volumes and concentrations and weight loss in this group compared to controls.

We conclude that an MCT diet does not significantly affect the closure of experimental chylothorax and that malnutrition delays its closure.
219 THE KASAI OPERATION (HEPATOPORTAL-ENTEROSTOMY) FOR BILIARY ATRESIA — EXPERIENCE WITH 19 CASES

R. Mustard, B. Shandler, Department of Surgery.
The Hospital for Sick Children, Toronto

This is a personal series (B.S.) of 19 infants who have undergone hepatoportal-enterostomy as treatment of extrahepatic biliary atresia at the Hospital for Sick Children, Toronto.BILE flow adequate significantly to reduce the serum bilirubin concentration was achieved in six babies. In contrast to the experience of others ascending cholangitis has not been a problem in the group of patients in whom improvement was noted. All the extrahepatic tissue examined microscopically showed inflammatory cell infiltration. The diagnosis of biliary atresia, together with the pre- and postoperative management is discussed.

220 FACTORS INFLUENCING SUCCESS WITH HYDROSTATIC REDUCTION OF ILEOCOLIC INTUSSUSCEPTION

A. Thoma, G. Y. P. Lau, D. Rogers, G. S. Cameron.
McMaster University Department of Surgery,
St. Joseph's Hospital, Hamilton

The efficacy of hydrostatic reduction of ileocolic intussusception is now universally accepted, but reported success rates vary greatly and it is difficulty to identify the factors influencing success or failure.

Recently, the routine use of glucagon has been advocated, based on an uncontrolled clinical trial which appeared to show that this had produced an improved hydrostatic reduction rate of 84% in 25 consecutive cases.

During the 5 year period 1973 to 1977, we experienced a similar success rate of 83% in 23 consecutive cases, using a standard treatment protocol that did not include the use of glucagon. With 47 cases treated in the prior 10 years, our reduction rate had been 66%.

A detailed review of these 70 cases indicates that our improved success rate is partially caused by such uncontrollable factors as fewer cases with delayed presentation, but it appears primarily due to a more consistent and aggressive approach to hydrostatic reduction. The use of repeated fillings through a large foley catheter seems to be a particularly significant factor.

An 80% success rate can be achieved with a standard treatment protocol. However, reduction rates may vary due to differences in patient populations. Therefore meaningful comparison of results requires careful description of patient populations, and such adjunctive measures as glucagon can be evaluated only by prospective controlled clinical trials.
HABILITATION OF PATIENTS WITH SEVERE FACIAL DEFORMITIES BY CORRECTIVE CRANIO-ORBITAL SURGERY

Mutaz B. Habal and Jack E. Maniscalco,
USF College of Medicine, Tampa

For centuries children born with major facial deformities and no other functional abnormalities have their major treatment concentrated on giving a name to their syndromes. Some of such patients with normal mental ability reside in retardation institutions mainly because of their deformities and have mental deprivation over the years. The experience after World War II in operating on casualties with major facial disfigurements was the main step that made pioneers in the field direct their attention to the children with facial deformities. The complexity of these operative maneuvers made it impossible for such surgery to be practiced in every hospital in the continent. Over ten centers are performing these procedures and providing a rehabilitative program for selected patients. The anatomic problem of hypertelorisms and lack of fusion is remedied by moving the orbits together. The problem of shallow orbits in exorbitism is corrected by moving the orbits forward. We are moving to selecting younger patients for these operative procedures. Patients with acquired disfigurements from tumor resection or trauma are finding better methods of rehabilitation. Our experience is presented in over 60 patients with long term follow-up. The major complications are related to brain edema, and its avoidance is practiced by preventive measures and careful monitoring of the patients during the operative procedure.
RHABDOMYOSARCOMA IN CHILDREN

M. Duhaime, J. M. Pagé,
Hôpital Ste-Justine, Montréal

This is a retrospective study of Rhabdomyosarcoma in children treated at l'Hôpital Sainte-Justine de Montréal.

A tentative logical clinical staging and classification will be attempted. The multidisciplinary approach has given an improvement in the survival rate.

Twenty-nine cases are reviewed. Staging was attempted based on the Intergroup Rhabdomyosarcoma Study. Use of the electron microscope was helpful for the histological classification.

The survival rate was improved with a strict staging of the tumor and with an aggressive polychemotherapy.

A comparison is made with other centers considering surgery alone, surgery with radiotherapy, and finally surgery with radiotherapy and chemotherapy. The factors affecting prognosis can be established at the time of diagnosis.

The follow-up period varies from 1 to 10 years.

29 cases, 1955 - 1977

16 + 13 +

Var

W. Augustin
STATUS OF LUNG FUNCTION AT FOLLOW-UP IN PATIENTS WITH REPAIRED CONGENITAL DIAPHRAGMATIC HERNIA

N. E. Wiseman, L. Rosenfield, R. Pagtakhan,
University of Manitoba, Section of Pediatric General and Cardiothoracic Surgery,
Children’s Centre, Winnipeg

A follow-up study of 11 patients who had previously undergone successful surgical treatment for congenital diaphragmatic hernia was conducted. In the majority of patients hernia repair had been performed in the neonatal period and the age at the time of the study ranged from 5 to 20 years. Participants in the study had a clinical evaluation, a radiographic chest examination, including fluoroscopy, a complete spirometric pulmonary function test, and a Xenon ventilation-perfusion lung scan. The results of this study were as follows. Radiologic examination showed evidence of over-inflation in 73% of patients and a decrease in pulmonary vascularity in 64%. Fluoroscopy demonstrated diaphragmatic abnormalities in 91% of patients. Spirometric examination revealed normal static lung volumes. However, measurements of flow showed F.E.V. .5 to be low in 50% of patients. Radiospirometric evaluation revealed 75% of patients to have decreased ventilation on the ipsilateral side and, in all patients, perfusion was noted to be diminished on the ipsilateral side. From this follow-up study, it appears that patients with previously repaired congenital diaphragmatic hernia have increased lung volume and decreased perfusion on the ipsilateral side and, as well, appear to have increased small airways resistance.
224 BRONCHIAL COMPRESSION SYNDROME IN INFANTS

P. G. Ashmore, Division of Pediatric Surgery, Vancouver General Hospital, and University of British Columbia, Vancouver

Life threatening bronchial compression can occur in infants suffering from cardiac or pulmonary lesions which distract attention from the cause of the compression. In cases of pulmonary atresia the remaining lung may be displaced so that the great vessels compress the bronchus. In the "Tetralogy of Fallot with Absent Pulmonary Valve Syndrome" the pulmonary arteries are very large and cause bronchial compression. Cases will be described where conservative surgical procedures on the great vessels resulted in significant and lasting symptomatic improvement.

225 ENDODERMAL SINUS (YOLK SAC) TUMORS IN INFANTS AND CHILDREN

A. W. Juckes, M. M. Fraser, D. Dexter, Departments of Surgery and Pathology, University of Saskatchewan/Regina, Pasqua and Regina General Hospitals, Regina

Endodermal Sinus Tumors, as a specific entity, were first proposed and described by Teilum on the basis of morphological and histogenetic features. Recent work utilizing tumor markers (Alpha-fetoprotein), immunofluorescent, and electron microscopic studies have supported Teilum's original concept as to the origin of these tumors.

Five typical presentations of endodermal sinus tumors seen in the pediatric age group will be reviewed with reference to the original histopathological concept, the clinical presentation, the utilization of tumor markers (Alpha-fetoprotein) and the prognostic implications of this neoplasm.

41/yr - Sacr. Scored + APP positive, all died

1yr - Value

8yr - Away

15yr - Tumor

10yr - Tumor, after 30 yrs

Ensure APP + Alpha fetoprotein (VAC better)
L'HÉMOBILIE: CETTE MÉCONNUE

Hervé Blanchard, Quang Nhan Ho,
Arié Léon Bensoussan, Pierre-Paul Collin,
Jean G. Desjardins, Département de Chirurgie,
Hôpital Sainte-Justine, Montréal

De 1962 à 1978, 28 enfants de 1 à 18 ans ont été traités en chirurgie à Ste-Justine pour traumatisme hépatique sévère. Soixante-dix pour cent était des garçons. Les accidents de circulation (auto-piéton) étaient en cause chez 75% des patients. Chutes de bicyclette, d'une certaine hauteur, accident de motoneige et plaie par arme blanche furent en cause chez 25% des patients. La majorité des accidents sont survenus l'été. Une relation notable existe entre la mortalité et le nombre de lésions liées à la lésion hépatique.

Parmi ces 28 patients, 4 (14.2%) ont présenté des hémorragies digestives massives hautes, basses et par un tube en T 48 h à 20 jrs après leur trauma initial. Chez 3 patients, il a été décelé que ces hémorragies provenaient des voies biliaires et l'hémobilie fut diagnostiquée. Ces 3 patients furent traités chirurgicalement avec succès (2 lobectomies droites et une résection des segments 2 et 3). Le 4e patient décéda de choc hémorragique à la suite de laparotomies libératives sans que la lésion n'ait pu être identifiée et traitée.

Mode de présentation, physiopathologie, investigations pertinentes et traitement de l'hémobilie seront discutés. Notre expérience nous fait penser que la résection hépatique réglée semble être le traitement de choix chez ces patients.

L'hémorragie digestive massive survenant chez un grand traumatisé de l'abdomen doit faire penser à l'hémobilie que Fitzpatrick a nommée à juste titre "The neglected syndrome" car il est rarement diagnostiqué.
CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
EDUCATION FUND

ASSOCIATION CANADIENNE DE CHIRURGIE INFANTILE
FOND D’ÉDUCATION
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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 pédiatique lors de la réunion de la Société Canadienne de Pédiatrie. Il rend possible une participation élaborée de notre Association au programme scientifique du Congrès Annual du College 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.

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