Annual Meeting
Réunion Annuelle

Toronto

Sept. 15 - 16, 1981

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

programme schedule

Sept. 15 - 16, 1981
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.
Future Annual Meetings

51st Annual Meeting
Quebec City, Que.
September 13 - 17, 1982

52nd Annual Meeting
Calgary, Alta.
September 19 - 23, 1983

53rd Annual Meeting
Montreal, Que.
September 10 - 14, 1984

54th Annual Meeting
Vancouver, B.C.
September 9 - 13, 1985

55th Annual Meeting
Toronto, Ont.
September 8 - 12, 1986

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
1979-1980    Pierre Paul Collin    Montreal
1981-1982    Barry Shandling    Toronto

SECRETARY- TREASURER
1967-1973    Barry Shandling    Toronto
1974-1978    Gordon Cameron    Hamilton
1978-        Frank Guttman    Montreal
canadian association of pediatric surgeons

Tuesday, September 15  0900  HOSPITAL FOR SICK CHILDREN

CHAIRMAN: Raymond Cloutier, Québec

0900  ANNUAL BUSINESS MEETING

1000  COFFEE INTERMISSION

1030  FRED McLEOD LECTURE - EXTRAHEPATIC PORTAL HYPERTENSION:
H. William Clatworthy, Columbus, Ohio, U.S.A.

ABSTRACT
NO.
236  1115  CONGENITAL DIAPHRAGMATIC HERNIA: A NEW THERAPEUTIC APPROACH. R. Cloutier, L. Lavasseur, Department of Surgery, Le Centre Hospitalier de l'Université Laval, Sainte-Foy


238  1145  REPAIR OF ECTOPIA CORDIS: A.R.C. Dobell, H.B. Williams, R.W. Long, McGill University Division of Cardiovascular and Thoracic Surgery, Montreal Children's Hospital, Montreal

239  1200  TRAUMATIC BRONCHIAL INJURIES IN CHILDREN: S.H. Ein, J. Friedberg, B. Shandling, J. Simpson, B. Farrow, The Hospital for Sick Children, Toronto

240  1215  CHYLOTHORAX: CHYLOPERICARDIUM WITH MULTIPLE LYMPHANGIOMA: LYMPHOPHAGIC STUDY: EVOLUTION AND MANAGEMENT. J.C. Ducharme, R. Bélanger, Département de Chirurgie et de Radiologie, Hôpital Sainte-Justine, Université de Montréal, Montréal
canadian association of pediatric surgeons

Tuesday, September 15 1400 HOSPITAL FOR SICK CHILDREN

CHAIRMAN: Gary Mackie, Montreal

ABSTRACT NO.

241 1400 TORSION OF THE WANDERING SPLEEN: SPLENECTOMY OR SPLENOPEXY?: G. Stringel, P. Soucy, S. Mercer, Department of Surgery, Children's Hospital of Eastern Ontario, Ottawa


243 1430 INTUSSUSCEPTION — THE MECHANISM OF PERFORATION OF DISTAL BOWEL (INTUSSUSCIPiens) AT BARIUM ENEMA IN A SPECIAL AT RISK GROUP: S. Mercer, Department of Surgery, Children's Hospital of Eastern Ontario, University of Ottawa, Ottawa

244 1445 DUODENAL ATRESIA WITH GAS IN THE BOWEL BELOW THE LEVEL OF THE OBSTRUCTION: K. Hoddinott, R.F. Kennedy, S. Bridger, The Dr. Charles A. Janeway Child Health Centre, St. John's

245 1500 DUODENAL ATRESIA DIAGNOSED BEFORE BIRTH BY ULTRASOUND: T.K. Goodhand, N.E. Wiseman, St. Boniface General Hospital, Department of Surgery, University of Manitoba, Winnipeg

246 1515 KASAI OPERATION FOR ATRESIA OF THE BILE DUCTS (ABD) — CURE OR PALLIATION: H. Blanchard, A.L. Bensoussan, Hôpital Ste-Justine, Université de Montréal, Montréal

1530 COFFEE INTERMISSION

247 1600 EXPERIENCE AND LONG TERM FOLLOWUP ON 67 CASES OF HIRSCHSPRUNG'S DISEASE: R.W. Cram, Department of Surgery, College of Medicine, University of Saskatchewan, Saskatoon

248 1615 THE UMBILICUS AS A SITE FOR TEMPORARY COLOSTOMY IN INFANTS: G. Cameron, G. Lau, Pediatric Surgery Service, McMaster University Medical Centre, Hamilton

249 1630 THE KRASKE APPROACH TO THE REPAIR OF RECURRENT RECTOURETHRAL FISTULA: N.E. Wiseman, A. Dector, University of Manitoba, Department of Surgery, Children's Hospital and St-Boniface General Hospital, Winnipeg

250 1645 CLOACAL TYPE OF IMPERFORATE ANUS AND NEONATAL URINARY ASCITES: MANAGEMENT AND EXPLORATION: C.G. Mackie, Division of Pediatric Surgery, The Montreal Children's Hospital, Montreal

Wednesday, September 16 0900 QUEBEC ROOM (Royal York)

CHAIRMAN: Robert Filler, Toronto

ABSTRACT NO.

251 0900 EXPERIENCE WITH PERITONEO-VENOUS SHUNTING FOR CONGENITAL CHYLOUS ASCITES IN INFANTS AND CHILDREN: F.M. Gutman, P. Montpetit, R.S. Bloss, Departments of Pediatric Surgery, Ste Justine Hospital and Montreal Children's Hospital, University of Montreal and McGill University, Montreal

252 0915 RESULTS OF CLEAN INTermittent CATHeterIZATION (C.I.C.) IN CHILDREN LESS THAN THREE YEARS OF AGE: R. Perez-Marrero, W. Dimmock, B.M. Churchill, B.E. Hardy, Urology Department, The Hospital for Sick Children and The Ontario Crippled Children's Centre, Toronto

253 0930 THE SIGNIFICANCE OF FEVER FOLLOWING OPERATIONS IN CHILDREN: R.S.W. Yeung, J.R. Buck, R.M. Filler, The Hospital for Sick Children, Toronto

254 0945 FACTITIOUS PANCREATITIS IN CHOLEDOCHAL CYST: G. Stringel, R. Filler, Department of Surgery, Children's Hospital of Eastern Ontario and The Hospital for Sick Children, Toronto

255 1000 VATER ASSOCIATION AND UNRECOGNIZED BRONCHOPULMONARY FOREGUT MALFORMATION COMPLICATING ANESTHESIA: M.A. Bleicher, A.P. Melmed, X.V. Bogaerts, G.S. Sklar, The Mount Sinai Medical Center, N.Y.C. and City Hospital Center at Elmhurst, NY

256 1015 COLONIC PREPARATION BY WHOLE BOWEL IRIGATION IN PEDIATRIC PATIENTS: R. Postuma, Children's Hospital, Department of Pediatrics and Surgery, University of Manitoba, Winnipeg

257 1030 INFANTILE MULTICYSTIC KIDNEYS: ITS MANAGEMENT AND A NEW EXPLORATION OF THE ABNORMALITY: G.G. Mackie, S.S. Parulkar, Division of Urology, The Montreal Children's Hospital, Montreal

258 1045 A STUDY OF 100 PEDIATRIC SURGICAL PATIENTS AGED 6 - 18 YEARS: J.C. Ducharme, F. Dion, G. Martineau, C. Pliamond et A. Plante, Hôpital Sainte-Justine, Montréal

1100 COFFEE INTERMISSION
symposium
pediatric surgery

Royal College in cooperation with the Canadian Association of Pediatric Surgeons

Wednesday September 16 1400 QUEBEC ROOM (Royal York)

TREATMENT OF INFLAMMATORY BOWEL DISEASE IN CHILDREN AND ADOLESCENTS

CHAIRMAN: Ray Postuma, Winnipeg

1500 GENERAL MEDICAL ASPECTS: Stanley Moroz, Pediatric Gastroenterologist, Winnipeg Children's Hospital, Winnipeg

1520 NUTRITIONAL THERAPY: Micheline Ste. Marie, Pediatric Gastroenterologist, Laval University, Quebec

1540 NEW CONCEPTS IN SURGERY OF ULCERATIVE COLITIS (ENDORECTAL PULL-THRU): Arnold Coran, Professor of Surgery, University of Michigan, Ann Arbor, Michigan, U.S.A.

1600 KOCH ILEOSTOMY: Zane Cohen, Gastrointestinal Surgeon, Toronto General Hospital, Toronto

1620 SURGICAL TREATMENT OF CROHN'S DISEASE: Arie Bensoussan, Pediatric Surgeon, St. Justine Hospital, Montreal

1640 QUESTIONS AND ANSWERS
CONGENITAL DIAPHRAGMATIC HERNIA. A NEW THERAPEUTIC APPROACH.

R. Cloutier, L. Levassor, Department of Surgery, Le Centre Hospitalier de l'Université Laval, Sainte-Foy, Québec.

Out of 25 cases of congenital diaphragmatic hernia transferred to our hospital, 22 were diagnosed in the first 24 hours of life. Twenty cases were operated upon and 2 died before any treatment could be applied.

We have 8 survivors and 12 deaths (including one at 6 months of age). Eleven patients died from persistent fetal circulation.

Assuming that hypoxia is the main factor of pulmonary hypertension in these patients, a new approach in the post-operative management was decided on a trial basis to prevent its occurrence. Post-operative drainage of the chest is not carried out any more, thus preventing rapid expansion of the ipsilateral lung. Rapid ventilation of the contralateral lung with minimal pressure provides adequate oxygenation.

This approach was applied in the last 3 patients with success. One of these patients was severely acidic and probably would not have survived with the classical treatment. This case is discussed in detail.

CONGENITAL STENOSIS OF INDIVIDUAL PULMONARY VEINS - REVIEW OF SURGICAL EXPERIENCE WITH REPORT OF ONE CASE.


Congenital stenosis of pulmonary veins (CSPV) is a rare condition, only 26 cases having been reported. 7/26 cases have received surgical treatment. Recently, 4 cases have been reported at our hospital, only 1 of which was diagnosed antemortem. In the 4th case, a 15 year old girl, both veins from the right lung were stenosed at their venous atrial junction. At thoracotomy, patch repair of the stenosed ostia was effected. Lung scan 2 weeks and 4 months post-op showed no perfusion in affected lung. Right pneumonectomy is now being considered. Of the 7 reported surgical cases, 1 case (2/4 veins) treated by pneumonectomy, is well. Of the 6 cases treated by repair, 4 (2/4, 3/4, 3/4, 3/4, 3/4 veins) died shortly post-op. 1 (2/4 veins) is alive but not improved, and 1 (3/4 veins) was alive and improved 2 years post-op.
CSPV or atresia may affect 1 or all veins. While frequently ostial, it may occur anywhere in the intra or extra pulmonary course of the vein(s). Affected lobes demonstrate marked proliferation in bronchial circulation, making surgical treatment difficult.

We conclude that because of the nature of the pathology, (1) direct repair of CSPV is rarely possible, (2) any form of surgery with 3/4 or 4/4 vein involvement is likely to be unsuccessful and (3) with 1/4 or 2/4 vein involvement, repair may be attempted if pathology is favorable, but lobectomy or pneumonectomy will probably be required.

238 REPAIR OF ECTOPIA CORDIS.
A.R.C. Dobell, H.B. Williams, R.W. Long, McGill University
Division of Cardiovascular and Thoracic Surgery, Montreal
Children's Hospital, Montreal.

A neonate with ectopia cordis underwent a lifesaving operation in Calgary by Dr. C. Geoffrey F. Saogram to provide skin coverage. Subsequently he presented to us. Heart catheterization disclosed a normal heart. Surgical repair of the chest wall was carried out after nine months of reflection. The principles applied here were to avoid myocardial compression and to use only autogenous tissue in constructing a solid barrier between heart and skin. Segments of five ribs proved extremely satisfactory. The procedure will be demonstrated with a moving picture.

239 TRAUMATIC BRONCHIAL INJURIES IN CHILDREN.
Sigmund H. Ein, Jack Friedberg, Barry Shandling, James
Simpson, Blair Fearon, The Hospital for Sick Children,
Toronto, Ontario, Canada.

In the last 5 years at our hospital 4 children have suffered major bronchial injuries from motor vehicle accidents. Their ages ranged from 3 to 11 years and all were in some respiratory distress from their rightsided injuries. Three of the 4 had unresolved pneumotalcates, which required emergency bronchoscopy in 1, followed by thoracotomy in 3. Major bronchial tears were found in 2 places: the junction of right upper lobe and main bronchus, the junction of the right middle and lower lobe bronchi. The rents were all repaired without difficulty. Two upper lobes were lacerated, one of which was removed. Two children required postoperative ventilation for 4 to 15 days. The 2 “upper lobe children” have required up to 6 bronchoscopies to remove silk sutures and granulations from the repair site.

One of the “middle and lower lobe children” has required no post repair bronchoscopy, possibly because her bronchial tear was spiral in nature. The 4th child presented with a right pneumothorax and massive subcutaneous emphysema which responded to a chest tube. She then had persistent middle and lower lobe collapse due to a stenosis in the area of the middle and lower lobe bronchi. This responded to dilatations.

240 CHYLOTHORAX, CHYLOPERICARDE AVEC
LYMPHANGIOME MULTIPLE DE L’OS. ÉTUDE
LYMPHOGRAPHIQUE, ÉVOLUTION ET TRAITEMENT.
Jacques Charles Ducharme et Raymond Bélanger,
Départements de Chirurgie et de Radiologie, Hôpital
Sainte-Justine, Université de Montréal, Montréal, Québec.

Cette présentation porte sur une malformation complexe du système lymphatique chez un garçon de 7 ans, qui s’est compliquée d’un chylothorax gauche et d’un chylorécardie.

Le patient a été traité successivement par:
- Diète à triglycérides à chaîne moyenne PLUS ponction pleurale hebatomadaire pendant 3 semaines
- Alimentation entière au Vivonex PLUS ponction pleurale hebdomadaire pendant 3 semaines
- Alimentation parentérale exclusive PLUS ponction pleurale hebdomadaire pendant 3 semaines
- Alimentation parentérale exclusive PLUS drainage pleural sous l’eau pendant 3 semaines.

Malgré ces mesures l’épanchement qui s’accumulait au rythme de 75 cc/jour au début a augmenté jusqu’à 300 à 500 cc/jour. L’enfant cependant restait en bonne condition nutritionnelle.

L’exérèse chirurgicale incomplète du tissu lymphangiomeux qui entourait les vaisseaux de la base du cœur et une partie du récardie n’a pas corrige la situation. Cependant 2 injections de 25 cc de glucose 50% dans la cavité pleurale effectuées les 29 et 30 mars ont tari le drainage pleural du jour au lendemain.

Le travail illustre l’apport de la lymphangiographie dans la pathogénie du chylothorax et les difficultés du traitement.
241 TORSION OF THE WANDERING SPLEEN
Splenectomy or Splenopecty.

G. Stringel, P. Soucy, S. Mercer. Department of Surgery,
Children’s Hospital of Eastern Ontario, Ottawa, Ontario,
Canada.

Torsion of the wandering spleen is a rare condition usually unsuspected preoperatively.

In previously reported cases in the past, attempts of splenectomy have failed and splenectomy has been regarded as the treatment of choice.

We are presenting 2 children with splenic torsion. In one complete infarction of the spleen had occurred and so splenectomy could not be avoided. In the second, the spleen was viable and splenectomy was successfully performed.

The clinical presentation, etiology, diagnostic procedures and management are discussed. We are describing a simple technique for splenopecty. We advocate splenectomy in all cases of wandering spleen. Splenectomy should be performed only in patients with splenic torsion in whom massive infarction and thrombosis of the splenic vessels has occurred.

242 A RETROSPECTIVE STUDY OF SPLENECTOMIZED
CHILDREN AT THE I.W.K. HOSPITAL FOR CHILDREN,

H.O. Nason and Dawn L. Ross, I.W.K. Hospital for Children,
Halifax.

Should our splenectomized patients receive prophylactic antibiotics? If so, which drug and how long? What is the risk? How conservative should we be as surgeons? Our own answers are discussed in the light of a retrospective look at 122 splenectomies performed between 1963 and 1979, as well as a literature review. No cases of overwhelming post-splenectomy infection occurred in our series.

243 INTUSSCUSPTION - THE MECHANISM OF
PERFORATION OF DISTAL BOWEL
(INTUSSUSCIPiens) AT BARIUM ENEMA IN A SPECIAL
AT RISK GROUP.

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

All cases (120) of intussusception seen at the Children’s Hospital of Eastern Ontario (1974-1981) have been analysed. A special age group (under 11 months) has been identified to be at risk with respect to grossly delayed diagnosis and irreducibility (hydrostatically and operatively). All resections but one were in this age group and no deaths occurred. One perforation, during attempted hydrostatic reduction occurred, and was in this group. As is usually described in the literature, perforation occurred distal to the intussusceptum and not through it. The significance of the site of the perforation has not previously been clear. It is shown to be secondary to intussusception of the blood supply of the distal bowel with gross damage to its wall. The blood supply of this segment of bowel has received little or no attention in the past. Attempted hydrostatic reduction of intussusception is therefore contraindicated in this "at risk" age group.

244 DUODENAL ATRESIA WITH GAS IN THE BOWEL
BELOW THE LEVEL OF THE OBSTRUCTION.

K. Hoddinott, R.F. Kennedy, S. Bridger, The Dr. Charles A.
Janeway Child Health Centre, St. John’s, Newfoundland.

This finding, although rare, has been reported in the literature and has been reported in the literature and has been explained on the embryological development of a bistd hepato-pancreatic duct with an orifice on either side of the atresia.

This case which at operation was proven to be of a complete duodenal atresia was not diagnosed pre-operatively as abdominal X-rays showed abundant gas in the bowel. As gas in the bowel of a newborn is swallowed air, then the only explanation for the above findings is of such a bistd hepato-pancreatic duct.
DUODENAL ATRESIA DIAGNOSED BEFORE BIRTH BY ULTRASOUND.

T.K. Goodhand, N.E. Wiseman. St. Boniface General Hospital, Department of Surgery, University of Manitoba

Three infants with duodenal atresia were correctly diagnosed prior to birth on the basis of ultrasound examination. Two of the infants were siblings. The indication for ultrasound examination was the presence of polyhydramnios. At birth the diagnosis of duodenal atresia was confirmed by the presence of a large volume of gastric contents and by the subsequent radiographic appearance of the infant's abdomen. In each infant early surgical repair resulted in a successful outcome. Polyhydramnios which occurs in 1/2% of pregnancies is well known to be associated with fetal abnormalities. In the infant with duodenal atresia there is often a history of polyhydramnios (45-75%) and it would thus appear that many of these infants could be diagnosed before birth. The advantages of antenatal diagnosis include: early neonatal surgical repair with the avoidance of emesis, aspiration pneumonia, and dehydration. As well, this may allow early detection of associated anomalies such as midgut volvulus. With antenatal diagnosis the overall morbidity and mortality associated with duodenal atresia can be improved.

OPERATION DE KASAI POUR ATRÉSIE DES VOIES Biliaires (AVB) CURE OU PALLIATION.

Hervé Blanchard et Arié Léon Bensoussan, Hôpital Ste-Justine, Université de Montréal.

Les auteurs rapportent leur expérience de 17 cas d'AVB du type non corrigeable (type III) traités à l'Hôpital Ste-Justine de 1974 à 1980. L'âge à l'intervention: 45 à 105 jours, moyenne de 75 jours.

Quatorze enfants eurent une porto-entérostomie et 8 jejunostomies cutanées décompressives. Trois patients eurent une porto-cholécystostomie.

Évaluation des résultats fonctionnels: groupe A: 6 patients vivants, anicteriques avec une bilirubinémie inférieure à 1,5 mg/dl; groupe B comprenait initialement 5 patients ayant une régression partielle de l'ictère, une bilirubinémie de 1,5 à 5 mg/dl, 2 de ces 5 patients eurent un arrêt d'excrétion biliaire 1/2 mois et 3 mois après l'intervention, les 3 autres patients sont décédés de cholangite, d'insuffisance hépatique; groupe C: 6 patients qui n'eurent aucune excrétion biliaire.

EXPERIENCE AND LONG TERM FOLLOW UP ON 67 CASES OF HIRSCHSPRUNG'S DISEASE.

Robert W. Cram. Department of Surgery, College of Medicine, University of Saskatchewan, Saskatoon, Sask.

This paper covers a review of 67 cases of Hirschsprung's Disease in Saskatoon, Sask. with follow up for 5 years or longer in most patients. High segment (descending colon or higher) aganglionosis was present in over 25% of the cases and was managed by Rehbein type of procedure. Short segment (sigmoid colon or lower) patients were managed by the Swenson operation. The efficacy of Rehbein type of procedure used in the high segment cases is apparent in the long term follow up study. Even in some patients where the very high level of aganglionosis necessitated leaving longer than usual rectal stumps, the results are still very good.

Slightly over 1/3 of the patients with Hirschsprung's Disease were female.

A common finding in many cases was that there appeared to be recurrent bouts of constipation or diarrhea up to 2 or 3 years after resection; but, from then on, almost without exception, all cases did extremely well. Sometimes repeat sphincterotomy and dilatation was indicated in the early years.

Another aspect of the study is the long term results in ultra short segment aganglionosis treated by sphincterotomy and dilatation.
248 THE UMBILICUS AS A SITE FOR TEMPORARY COLOSTOMY IN INFANTS.

G. Cameron, G. Lau. Pediatric Surgery Service, McMaster University Medical Centre, Hamilton.

The umbilicus has been used as a site for temporary colostomy in 7 infants with imperforate anus or Hirschsprung’s disease.

The technique is adaptable to both loop (double-barreled) colostomy and divided colostomy. A circumferential incision is made at the umbilicus, and the umbilical vessels are individually ligated. Colon is sutured to fascia and a protruding colostomy stoma fashioned by the Turnbull method. The colostomy is managed with disposable ostomy bags. After definitive surgical correction of the primary problem, the colostomy is closed, fascia repaired, and the circular skin defect closed in a purse-string manner.

Use of the umbilicus as a colostomy site facilitates the use of colostomy appliances in small infants, and after closure leaves a scar which closely mimics a normal umbilicus.

249 THE KRAUSKE APPROACH TO THE REPAIR OF RECURRENT RECTOURETHRAL FISTULA.

N.E. Wiseman, A. Decler, University of Manitoba,
Department of Surgery, Children’s Hospital and St. Boniface General Hospital, Winnipeg.

Rectourethral fistula is a common complication of surgery for repair of imperforate anus in the male. A number of different operative approaches to the repair of recurrent rectourethral fistulas have been described. These include: transperineal, abdominal perineal, transanal, and transurethral operations. All procedures are associated with a significant failure rate. Two patients with recurrent rectourethral fistulas are presented. The first patient was seen at age 5½ years following an unsuccessful attempt at fistula closure via the abdominal perineal approach. The second patient presented at age 28 years having had several failed attempts at closure of a rectourethral fistula. In both patients the successful repair of the rectourethral fistula was carried out through a Kraske approach. The operative procedure involves: 1) Defunctioning colostomy and cystostomy. 2) Catheter intubation of the fistula. 3) Kraske approach to the rectum. 4) Transrectal isolation and closure of the fistula. 5) Sleeve resection of the rectum and primary anorectal anastomosis. The success of this operative technique is based upon the principle of avoiding overlapping suture lines at the site of the fistula repair.

250 CLOACAL TYPE OF IMPERFORATE ANUS AND NEONATAL URINARY ASCITES: MANAGEMENT & EXPLORATION.


Cloacal malformation represents the most severe type of imperforate anus in the female. It corresponds to the high imperforate rectum in the male with the added complication of intrusion of mullerian duct structures onto the undivided rectum and bladder.

The last five cases seen at The Montreal Children’s Hospital with cloacal type of imperforate anus all had associated midline abdominal masses and fetal urinary ascites.

The association of urinary ascites with this malformation has not been previously reported. Two of these cases died due to the severity of the malformation. Another early case in the series died secondary to peritonitis from the urinary ascites.

The two most recent cases survived due to drainage of urine from the urine trapping vagina preventing development of urinary ascites and peritonitis. Management of these children must be directed towards early diagnosis, prompt drainage of the urine in the cloaca and early diverting colostomy. In all these children the formation of the cloaca caused a “urine trapping vagina”. Overdistension of the vagina resulted in a mid abdominal mass and retrograde urine flow to the peritoneal cavity.

A review of the five cases will be presented, management discussed and an embryological explanation of why these cases result in urine trapping and fetal urinary ascites will be presented.

251 EXPERIENCE WITH PERITONEO-VENOUS SHUNTING FOR CONGENITAL CHYLIOUS ASCITES IN INFANTS AND CHILDREN.

F.M. Guttman, P. Montpetit, R.S. Bloss. Departments of Pediatric Surgery, Ste Justine Hospital & Montreal Children’s Hospital, University of Montreal & McGill University, Montreal.

The literature is bereft of reports of the long term function of synthetic shunts when used for chylous ascites. We present two patients with chylous ascites unresponsive to medical management who were treated with peritoneo-venous shunting. For the first patient, a LeVeen
shunt was inserted at 7 weeks of age for refractory chylous ascites and severe respiratory distress. The shunt seemed to work for two weeks, after which, the abdominal distention and respiratory distress increased and a shunt occlusion was documented. The respiratory distress increased and the baby died of cardiac arrest of unknown etiology several weeks later. In the second patient, a Denver peritoneo-venous shunt was used. It was inserted at the age of six years for Milroy’s disease. This shunt also occluded on the second day after the operation. A second shunt was placed and this functioned well for one month before occlusion again occurred. Our experience suggests that shunting for chylous ascites in children is not indicated - it seems to be associated with a high incidence of occlusion. Modification of current devices may be needed to improve results, and this may be true also for chylous ascites in adults since long-term follow-up results are not available.

252 RESULTS OF CLEAN INTERMITTENT CATHETERIZATION (C.I.C.) IN CHILDREN LESS THAN THREE YEARS OF AGE.


A retrospective study of 34 children under 3 years of age with neurogenic bladder dysfunction was undertaken to show the effectiveness of C.I.C. in preventing renal deterioration. The age range was 7 days to 27 months with 23 children less than one month of age. Mean follow-up was 10 months. Only one patient was unable to continue C.I.C. Twenty-one patients were started on C.I.C. for upper tract changes or reflux, 9 for uncontrollable recurrent UTIs and 2 for inadequate bladder evacuation. Follow-up was adequate for analysis in 32 of these patients, (1 - 3 months). 91% of them showed improvement or stabilization of their condition and 9% showed deterioration or discontinued C.I.C. The urine infection rate was reduced from 44% to 22%.

C.I.C. has proven to be an effective way of preventing upper tract deterioration and urinary infections in these small children with neurogenic bladder dysfunction.

253 THE SIGNIFICANCE OF FEVER FOLLOWING OPERATIONS IN CHILDREN.


To determine the incidence and clinical significance of early postoperative fever, all children (n=56) undergoing surgery in the main operating theatres during a 4 week period were studied. Admission and operating room data were reviewed and the clinical record was monitored at 12 hourly intervals for the first 3 postoperative days. The patients were followed for 1 month for the development of recognizable complications.

Seventy-three children (28.5%) developed fever >38°C but in only 4 (1.6%) did this represent a septic process. Physical examination led to the proper diagnosis in all. Risk factors that correlated statistically with postoperative fever were: operation of greater than 2 hours (p<001), intra-operative transfusion (p<001), pre-existing infection (<01) and the use of preoperative antibiotics (p<001). Anatomic site of operation was not a significant factor.

We conclude that many factors other than infection are responsible for postoperative fever. Further, only a very small proportion of children with early postoperative fever develop significant septic complications. In the assessment of post-operative fever a protocol which indiscriminately includes lab investigations and x-rays is costly and usually not-diagnostic. Laboratory tests are indicated mainly to confirm diagnoses suspected by clinical evaluation.

254 FACTITIOUS PANCREATITIS IN CHOLEDOCAL CYST.

G. Stringel, R. Filler, Department of Surgery, Children’s Hospital of Eastern Ontario and the Hospital For Sick Children, Toronto.

The classical presentation of Choledocal cyst has been regarded as a triad of abdominal pain, jaundice and a palpable abdominal mass: unusual presentation include rupture of the choledocal cyst with bile peritonitis, pancreatitis and bleeding esophageal varices.
We are reporting 2 children presenting clinically as recurrent acute pancreatitis with elevated serum amylase and found to have type I choledochal cyst. Despite elevated serum amylase there was no evidence of pancreatic inflammation at laparotomy. High amylase concentration was found in fluid contained within the cyst. This was probably responsible for elevated serum amylase and also the inflammatory reaction seen in the wall of the choledochal cyst. These cases support the hypothesis that pancreatic reflux into the bile ducts is the etiological factor in development of choledochal cyst. Our 2 cases were treated by cyst excision and have remained asymptomatic. The presence of hyperamylasemia should not delay appropriate surgical management. The treatment of choice is cyst excision, since it will eliminate factors contributing to the development of cholangitis and hyperamylasemia.

255 VATER ASSOCIATION AND UNRECOGNIZED BRONCHOPULMONARY FOREGUT MALFORMATION COMPLICATING ANESTHESIA.

M.A. Bleicher, A.P. Melmed, X.V. Bogaerts, G.S. Sklar. The Mount Sinai Medical Center, N.Y.C. and City Hospital Center at Elmhurst, NY.

A neonate with VATER association accompanied by origin of the right main stem bronchus from the esophagus is reported. The patient died at age ten hours of massive hemorrhage from the upper gastro-intestinal tract during induction of anesthesia.

An awareness and understanding of this anomaly and its embryologic origin permits its recognition. Repair of the esophageal atresia and tracheo-esophageal fistula must be accompanied by treatment of the bronchopulmonary foregut malformation, if severe morbidity or mortality is to be avoided.

256 COLONIC PREPARATION BY WHOLE BOWEL IRRIGATION IN PEDIATRIC PATIENTS.

Ray Postuma, Children's Hospital, Winnipeg and the Department of Pediatrics and Surgery, University of Manitoba.

Whole bowel irrigation (WBI) was used in 15 patients, ages 8 to 17 on 16 occasions in preparation for colonoscopy (13), Barium enema (1), colon surgery (1) and treatment of drug overdose (1). An average of 8.5L warm saline with KC1 (5 mEq/L) was infused per nasogastric tube over 6.3 hours mean. This resulted in a weight gain of 1.9%, hematocrit decrease 1.5% and serum chloride increase of 8.8 mEq/dl (mean values, post versus pre WBI). Vital signs remained stable and there were no complications.

The colonic preparation was complete in 8, adequate in 5, and unsatisfactory in 2. The overdose patient made a rapid recovery.

It is concluded that WBI is a satisfactory method of colonic preparation of Pediatric patients.

257 INFANTILE MULTICYSTIC KIDNEYS: ITS MANAGEMENT AND A NEW EXPLORATION OF THE ABNORMALITY.


The multicystic kidney is one of the most common abdominal masses presenting in the neonate.

A pre-operative diagnosis is easily made by means of examination, ultrasonography, intravenous pyelography, and a technetium nuclear scan of the kidney. Diagnosis should lead to removal of the mass in the neonatal period as these masses are less palpable in infancy due to differential growth. These masses if left may result in infectious hypertension and ultimately carcinoma.

These masses are generally explained on the basis of uterine atresia leading to cystic malformation. A review of 10 cases at time of diagnosis and surgery suggest that uterine atresia is not the cause but rather a secondary effect of abnormal contact of the ureteral bud with the developing kidney. Evidence of this concept provided by proof of cyst communication in all cases, and abnormally sited ureteric orifice in the seven of 10 cases examined cystoscopically.

The embryological explanation will be presented.
258 ENQUÊTE EFFECTUÉE AUPRÈS DE 100 PATIENTS DE 6 À 16 ANS HOSPITALISÉS EN CHIRURGIE PÉDIATRIQUE.

Jacques Charles Ducharme, François Dion, Germaine Martineau, Céline Plamondon et Alain Plante, Hôpital Sainte-Justine, Montréal, Québec.

Durant l’année internationale de l’enfant le Comité d’Humanisation des Soins de Sainte-Justine a effectué une enquête auprès de 100 patients hospitalisés en chirurgie. Les patients ont répondu au questionnaire après un minimum de 4 jours d’hospitalisation. Les perceptions des patients sur l’accueil et leur séjour à l’hôpital ainsi que de leur chirurgien et leur intervention chirurgicale ont été analysées par groupes d’âges.

Malgré des progrès réalisés durant les dernières années dans la préparation psychologique des patients devant subir une chirurgie, des lacunes ont pu être identifiées dans les communications provenant des parents, du personnel et des chirurgiens surtout dans le groupe de 6 à 12 ans.

Des mesures propres à corriger ces lacunes ont été instituées.
FOND D'EDUCATION

Le fond d'éducation permet d'inviter chaque année d'éminents chirurgiens pédiatres 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 Pédriatrie. 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 défayer 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 défayer 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. F. M. Guttman
Secrétaire-trésorier
Association Canadienne de Chirurgie Infantile
2300 rue Tupper, Ste C-1129
Montreal, P.Q.
H3H 1P3

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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, 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.

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F.M. Gutman, M.D.
Secretary-Treasurer
Canadian Association of Paediatric Surgeons
2300 Tupper St., C-1129
Montreal, P.Q.
H3H 1P3

HONORARY MEMBERS

Professor J.H. Louw
University of Cape Town
Dept. of Surgery
Medical School, Observatory 7925
Cape Town, South Africa

Mr. Barry O'Donnell MCh, FRCS, FRCSI
Our Lady's Hospital for Sick Children
Crumlin
Dublin 12, Ireland

Mrs. Donald S. Paterson
131 Ridgedale Road
Charleswood
Winnipeg 20, Manitoba

Professeur D. Pellerin
Hôpital des Enfants Malades
9 Avenue Frederic Le Play
Paris VII, France

Dr. F. Douglas Stephens
Department of Urology
Children's Memorial Hospital
2300 Children's Plaza
Chicago, Ill. 60614

Dr. Micael S. Allen
Suite 210
688 Coxwell Avenue
Toronto, Ontario
M4C 3B7
(416) 466-1220

Dr. Phillip G. Ashmore
Fairmont Medical Bldg.
Suite 1206
750 W. Broadway
Vancouver, B.C.
V5Z 1J2
(604) 879-4324

Mr. David J. Waterston
CHS, FRCS
Consultant Surgeon
Hospital for Sick Children
Great Ormond Street
London, England WC1 3JH

Dr. Orvar Swanson
Main Street
Rockport, Maine 04856

Dr. A.W. Wilkinson
CHM, FRCS
Institute of Child Health
30 Guilford St.
London, England
WC1 INH

Mr. Douglas Cohen
Head, Department of Surgery
Royal Alexandra Hospital for Children
Camperdown, New South Wales, Australia 2050

Mabel McMillen
Apartment 602
164 Paris Road
Brantford, Ontario N3R 6K4

Mike and Toni
36 Hillholme Road
Toronto, Ontario
M3P 1PH
(416) 489-5338

Phil and Esther
3371 Point Grey Road
Vancouver, B.C.
V6K 1A4
(604) 738-4447

(604) 738-4947
Dr. James C. Donald  
1105 Pandora Avenue #220  
Victoria, B.C.  
V8V 3P9  
(604) 385-2451

Dr. Jacques C. Ducharme  
575 Dastelles #444  
Montreal, Quebec  
H3S 2C3  
(514) 737-5448

Dr. Fred W. Duval  
Medical Arts Bldg #1502  
233 Kennedy Street  
Winnipeg, Manitoba  
R3C 3J5  
(204) 943-7145

Dr. Sigmund H. Ein  
250 Lawrence Avenue W  
Suite 315  
Toronto, Ontario  
M5M 1B2  
(416) 781-1411

Dr. James C. Fallis  
Director, Emergency Medical Services  
Hospital for Sick Children  
555 University Avenue  
Toronto, Ontario  
M5G 1X8  
(416) 597-1500 #2426

Dr. Colin C. Ferguson  
Health Services Centre  
685 Bannatyne Avenue  
Winnipeg, Manitoba  
R3E OW1  
(204) 787-2598  
787-2465

Jim and Marie  
1220 Trans Port Road  
Victoria, B.C.  
V8S 5A3  
(604) 598-2572

Jacques and Monique  
640 Dawson  
T.M.R., Quebec  
H3K 1G6  
(514) 733-1537

Fred and Ethel  
255 Waverley Street  
Winnipeg, Manitoba  
R3M 3K4  
(204) 453-6216

Sigmund and Arlene  
9 Caravan Drive  
Don Mills, Ontario  
M3B 1M9  
(416) 444-5102

Jim and Barbara  
12 Parkhurst Boulevard  
Toronto, Ontario  
M4G 2C5  
(416) 487-2375

Colin and Angela  
255 Wellington Crescent #1105  
Winnipeg, Manitoba  
R3M 3V4  
(204) 475-5623

Dr. Robert Filler  
Hospital for Sick Children  
555 University Avenue  
Toronto, Ontario  
M5G 1X8  
(416) 597-1500

Dr. James D. Fischer  
College Plaza #602  
8215-112 Street  
Edmonton, Alberta  
T6G 2C8  
(403) 433-3107

Dr. Graham C. Fraser  
1204-750 West Broadway  
Vancouver, B.C.  
V5Z 1J2  
(604) 872-1323

Dr. Murray M. Fraser  
Medical Arts Clinic  
2125 11th Avenue  
P.O. Box 557  
Regina Saskatchewan  
S4P 0J6  
(306) 396-2603

Dr. D. Alexander Gillis  
5850 University Avenue  
Halifax, Nova Scotia  
B3J 3O8  
(902) 424-3113

Dr. David P. Girvan  
Colborne 1  
Victoria Hospital  
South Street  
London, Ontario  
N6A 4G5  
(519) 432-5977

Bob and June  
2 Harrington Road  
Don Mills, Ontario  
M3B 3G4  
(416) 449-2435

Graham and Rae  
6925 Cypress Street  
Vancouver, B.C.  
V5Z 1J2  
(604) 263-6160

Murray and Ruth  
33 Academy Park Road  
Regina, Saskatchewan  
S4R 0M8  
(306) 586-3862

Alec and Rose  
1612 Cambridge Street  
Halifax, Nova Scotia  
B3H 4A6  
(902) 422-3890

David and Beth  
929 Richmond St.  
London, Ontario  
N6A 3J3  
(519) 672-8662
Dr. Thomas K. Goodhand  
Abbott Clinic  
274 Osborne Street North  
Winnipeg, Manitoba  
R3G 1V8  
(204) 786-5481

Dr. A.E. Noelle Grace  
L.U.D.E. Children Centre  
4001 Leslie St.  
(416) 492-4662 or 3

Dr. Enrique Grisami  
Cleveland Metropolitan General Hospital  
3395 Scranton Rd.  
Cleveland, Ohio  
44109

Dr. Frank M. Guttman  
Montreal Children's Hospital  
2300 Tupper Street  
Montreal, Quebec  
H3H 1P3  
(514) 937-8511

Dr. David Hitch  
Assistant Professor of Surgery  
P.O. Box 26901  
Oklahoma City  
Oklahoma, 73180

Dr. Angus Luckes  
Regina General Hospital  
14th Avenue and St. John St.  
Regina, Saskatchewan  
(306) 523-5118

Dr. Ihab M. Kamal  
Doctors Building #345  
955 Queen Street East  
Sault Ste. Marie, Ontario  
P6A 2C3  
(705) 949-9143

Tom and Loreen  
1306 Wolseley Avenue  
Winnipeg, Manitoba  
R3G 1H4  
(204) 672-8662

Noelle and Morrie  
74 Don Woods Dr.  
North York, Ontario  
(416) 457-3018

Frank and Herta  
34 Upper Trafalgar Place  
Montreal, Quebec  
H3H 1T2  
(514) 989-9030

Dr. Gordon M. Karn  
Suite 1137  
Montreal Children's Hospital  
2300 Tupper Street  
Montreal, Quebec  
H3H 1P3  
(514) 937-8511

Dr. Richard Kennedy  
15 LeMarchant Road  
P.O. Box 4085  
St. John's, Newfoundland  
A1C 5Y2  
(709) 726-8155  
722-5100 #254

Dr. John W. Kerr  
Department of Surgery  
DIII 1  
Kingston General Hospital  
Kingston, Ontario  
K7L 2V7  
(613) 544-6133  
544-1426

Dr. Silvan Kleinhaus  
111 East 210th St.  
Bronx, N.Y. 10467  
(914) 472-1589  
(212) 967-4658

Angus and Marion  
22 Bole Place  
Regina, Saskatchewan  
S4S 3W7  
(306) 586-4499

Bob and Dilya  
78 Florin Drive  
Sault Ste. Marie, Ontario  
P6A 4J1  
(705) 949-7530

Gordon and Christine  
4830 de Maisonneuve W.  
Montreal, Quebec  
H3X 1M5  
(514) 931-6588

Dick  
1 Forest Road  
St. John's, Newfoundland  
(709) 726-8155

John and Beryl  
41 Cooperfield Drive  
Kingston, Ontario  
K7M 1M3  
(613) 544-0341

Murray and Beatrice  
4215 Cambie Street  
Vancouver, B.C.  
V5Z 2Y3  
(604) 876-0522

Sam and Mary  
9711-141 Street  
Edmonton, Alberta  
T5N 2H3  
(403) 452-6520
Dr. George Y.P. Lau  
25 Charlton Ave. E. #704  
Hamilton, Ontario,  
L8N 1Y2  
(416) 529-5732

Dr. Henry Lau  
The Isaac Walton Killam Hospital for Children  
5850 University Avenue  
Halifax, Nova Scotia  
B3H 1V7  
(902) 424-6194

Dr. Louis Levasseur  
2705 Boulevard Laurier  
Bureau 2211  
Ste Foy, Quebec  
G1V 4G2  
(418) 656-8168

Dr. Gilberto Antonio Lopez Perez*  
Eugenio Selles 15 30-A  
Malaga, Spain

Dr. G. Gary Mackie  
Montreal Childrens Hospital  
2300 Tupper Street  
Montreal, Quebec  
H3P 2V2  
(514) 937-8511

Dr. Donald G. Marshall  
600 Colborne Street  
London, Ontario  
N6B 2V2  
(519) 439-7381

Dr. Russell H. Marshall  
Fairmont Medical Building  
Suite 1314  
750 West Broadway  
Vancouver, B.C.  
V5Z 1J3  
(604) 737-7600/737-2420

George and Philoria  
1211 Appleford Lane  
Burlington, Ontario  
L7P 3M1  
(416) 632-2813

Henry and Asian  
5897 Inglis Street  
Halifax, Nova Scotia  
B3H 1K7  
(902) 422-3876

Louis and Giselle  
1330 Pelletier  
Sillery, Quebec  
G1T 2H4  
(418) 527-4861

Gary and Jeannie  
54 Aberdeen Avenue  
Westmount, Quebec  
H3Y 3A4  
(514) 933-5081

Don and Barbara  
55 Windsor Avenue  
London, Ontario  
N6C 1Z6  
(519) 438-2696

Russ and Larry  
3982 West 33 Avenue  
Vancouver, B.C.  
V6N 2H8  
(604) 266-4021

Dr. Adolfo Martinez-Caro*  
Ave. Reina Mercedes,31-20G  
Sevilla, Spain

Dr. Stealey Mercer  
Childrens Hospital of Eastern Ontario  
401 Smyth Road  
Ottawa, Ontario  
K1H 8L1  
(613) 737-7600/737-2420

Dr. David R. Murphy  
Montreal Childrens Hospital  
2300 Tupper Street  
Montreal, Quebec  
H3H 1P3  
(514) 937-8511

Dr. Harold O. Nelson  
5850 University Avenue  
Halifax, Nova Scotia  
B3J 5G6  
(902) 424-3111

Dr. Herbert F. Owen  
Montreal Childrens Hospital  
2300 Tupper Street  
Montreal, Quebec  
H3H 1P3  
(514) 937-8511

Dr. Gian Battista Giuseppe Faloschi  
Dept. of Surgery  
Hotel-Dieu Hospital  
Kingston, Ontario  
K7L 3H6

Dr. Raymond Postuma  
Childrens Hospital  
685 Bannatyne Avenue  
Winnipeg, Manitoba  
R3E 0W3  
(204) 775-8311 #205

Stan and Sylvia  
210 Buena Vista Road  
Ottawa, Ontario  
K1H 8L1  
(613) 737-2420

David and Beatrice  
134 Arlington Avenue  
Westmount, Quebec  
H3Y 2W4  
(514) 931-2732

Harold and Norma  
38 Overdale Lane  
Dartmouth, Nova Scotia  
B3A 3V3  
(902) 463-4053

Herb and Christine  
28 Picardy Road  
Baie d'Urfe, Quebec  
H9X 3G4  
(514) 457-5201

Ray and Jane  
232 Glenwood Crescent  
Winnipeg, Manitoba  
R2L 1J9  
(204) 668-7498
Dr. Steven Z. Rubin
Foothills Hospital
Calgary, Alberta

Dr. C. Geoffrey F. Seagram
1110 Sifton Blvd., S.W.
Calgary, Alberta

Dr. Barry Shandling
555 University Avenue
Suite 1526
Toronto, Ontario

Dr. James Simpson
555 University Avenue
Suite 1526
Toronto, Ontario

Dr. Pierre Sourcy
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario

Dr. Clinton A. Stephens
Medical Arts Building
Suite 619
170 St. George St.
Toronto, Ontario

Dr. Gustavo Stringel
Dept. of Surgery
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario

Dr. Peter Suderman
The Winnipeg Clinic
St. Mary's and Vaughan Winnipeg, Manitoba
K3C 0N2

Dr. William H. Taylor
26 Daleberry Place
Don Mills, Ontario

Dr. Nathan Wiseman
Rm. 210
Community Services Bldg.
Children's Centre
685 Bannatyne Avenue
Winnipeg, Manitoba


dr. Salam Yazbeck
3175 Chemin Cote Ste. Catherine
Hôpital Ste. Justine
Service de Chirurgie
Montreal, Quebec


Dr. Sami A Youssif
5757 Décelles Avenue
Suite 444 Montreal, Quebec

Dr. H. William Clatworthy, Jr., M.D.
Dept. of Pediatric Surgery
700 Children's Drive
Columbus, Ohio
U.S.A. 43209

Dr. Peter and Barbara
202 Harvard Avenue
Winnipeg, Manitoba
R3M 0K6

Bill and Jane
26 Daleberry Place
Don Mills, Ontario

Nathan and Eva
43 Folkstone Blvd.
Winnipeg, Manitoba

Jim and Jo
226 Inglewood Dr.
Toronto, Ontario

(416) 488-9912

Pierre
7 Valezcres
Ottawa, Ontario

(613) 737-2396

(613) 824-7766

(613) 731-0647

(613) 544-8448

(613) 961-2000

(416) 492-4662

(614) 474-1900

(614) 449-2526

(204) 775-8311 #370

(204) 474-1900

(204) 832-2805

(514) 747-6971

(514) 933-7221

NEW HONORARY MEMBER

Sami and Donna
21 Bellevue
Westmount, Quebec

(514) 933-7221

(514) 461-2000
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