32. Simmonds, J. P.: Chronic Occlusion of the Portal Vein. Arch. Surg., 33:397, 1936.
33. Talma, S.: Surgical Opening of a New Channel for the Blood of the Vena Pena Porta. Berlin klin. Wchnschr., 35:833, 1898.
34. Tuccu Tewelde, M.: Anatomy of the Abdominal Esophagus and Physiopathology of Esophageal Varices. Presse Med., 68:1697, 1960.
35. Turunen, M. and H. Laitinen: Collateral Circulation Between a Spleen Transposed into the Thoracic Cavity and the Vena Cava Superior. Ann. Surg., 149:443, 1959.
36. Tuffier, T. and Lejars: Veins of the Fatty Capsule of the Kidney. Arch. de Physiol. Norm. et Path., 3:41, 1891.
37. Umber, F.: A Contribution to Portal Vein Obstruction. Mitt. a. d. Grenzgeb. d. Med. u. Chir., 7:487, 1901.
38. Yi Yung Hsia, D. and S. Gellis: Portal Hypertension in infants and Children. Am. J. Dis. Child., 90:290, 1955.

Discussion

Dr. John Foster (Nashville): Drs. Johns and Evans were ingenious in taking advantage of this naturally occurring portal-systemic shunt which they enlarged by means of a venoplasty.

I think this case emphasizes the value of preoperative splenoportography or, in a case like this in which the spleen has already been removed, of operative portography in helping assess an individual case as regards alternate methods of treatment. Dr. Johns has certainly emphasized this in the manuscript.

This study of the portal collaterals and pathways has been of particular interest to us for several years, especially as regards the propensity of the spleen to develop collateral pathways when it is transposed into the left thoracic cavity. We did this in dogs, taking the lead from the Finnish group who first suggested it, and have been able to very clearly demonstrate the feasibility of shunting the blood from the portal system through the thoraco-splenic collaterals that form promptly after the spleen, with its pedicle intact, is placed in the left chest.

We would not like to give anyone the impression that we think this is a procedure for general application in portal hypertension but one which may find some applicability in selected cases in which it is not possible to perform a shunt procedure. (I.e., patients in whom a vein suitable for a porto-systemic is lacking, small children in whom a shunt has little chance of remaining patent, and possibly in very poor-risk patients who seem unable to tolerate a shunt operation.)