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RÉSUMÉ

Le problème des péricardites aiguës bénignes, bien étudié depuis 1942, à la suite de Barnes et Burchell, est présenté brièvement.

Les symptômes cliniques peuvent facilement en imposer pour une thrombose coronarienne, mais les examens poussés et, surtout, l'étude évolutive des ECG finissent par signer définitivement le diagnostic.

Le traitement est généralement reconnu comme illusoire—sauf, peut-être l'ACTH—mais, dans nos deux cas présentés, il semble que la streptomycine ait été responsable des bons résultats obtenus.

CONGENITAL ANOMALIES OF THE DIGESTIVE TRACT: REPORT OF TWO CASES

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MAJOR ANOMALIES of the digestive tract, fortunately rather rare, are now being treated with much more success than before. The main reasons for this are better preoperative and postoperative care and far better anæsthesia. But there is also another reason: it is the application to the newborn of the sound principles of surgical technique used on the adult. The tissues of a baby are not different from those of an adult, except that they are more fragile. Gentleness in handling tissues is an essential of good surgical technique; there is no place for rough handling of tissues either in the adult or the child. Therefore, if a surgeon is used to working properly and gently, he will not have more difficulty in operating on young babies than on adults, and his results will be the same.

To illustrate what has been said above, we are reporting two cases of anomalies of the digestive tract, severe enough to kill if proper surgical treatment had not been given, with a favourable outcome in both cases; the first case was one of spherical duplication of the second portion of the duodenum, and the second of atresia of the small bowel.

DUODENAL DUPLICATION

A boy, 15 days old, was brought to l'Hôtel-Dieu Notre-Dame de Beauce on April 23, 1955, because of vomiting and loss of weight. When he arrived, we were told that he had been normal during the first 10 days of his life; then he began to vomit, and the vomitus, bile-stained, became more and more frequent and abundant. His weight was 6 lb., a loss of 1 lb. in five days.

There were signs of moderate dehydration, with a pale yellow skin coloration; in the epigastrium, we had the impression of feeling a rather hard mass, but satisfactory examination was impossible. Two days later, a barium film revealed great enlargement of the duodenal pattern with evidence of obstruction at the duodenum.

Blood and glucose solution were given intravenously after venous dissection, and operation was performed on April 27, 1955. The abdomen was entered through a right paramedian incision; exploration revealed, on the medial side of the duodenum at the union of its second and third portions, a cystic formation nearly as big as a tennis ball, and causing such compression that the adjacent duodenum was elongated and absolutely flat (Fig. 1). We tried to dissect this mass free, but relations between the duodenum and the cyst were so intimate that dissection was impossible without injuring the duodenal walls.

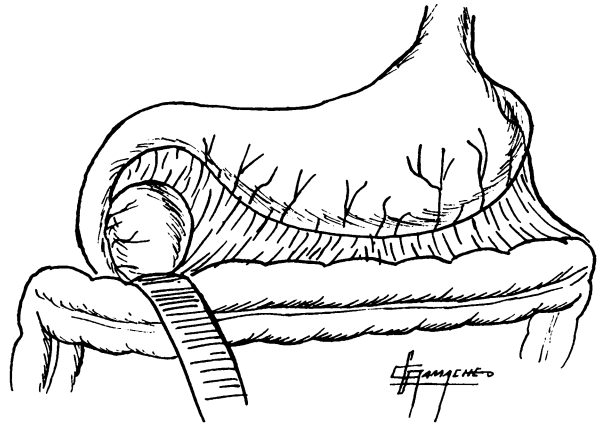

Fig. 1.—Spherical duplication of the duodenum, in the second and third portions; the duodenum was flatter than in the drawing.

After having clearly seen that the biliary and pancreatic ducts entered the duodenum about one inch (2.5 cm.) above the mass, we performed a resection of the duodenal segment along with the mass attached to it, and the operation was completed by a termino-terminal anastomosis between the proximal and distal parts of the duodenum.

A small tube was passed through the stomach into the duodenum for feeding and for suction; the abdomen was closed in three layers without drainage, and penicillin and streptomycin were left in the peritoneal cavity. During the operation, which lasted one hour and 50 minutes, the boy received 60 c.c. of blood and 100 c.c. of a mixture of glucose and saline solution.

For two days, he was hydrated parenterally and through the duodenal tube, which was then removed. At the beginning, there was some bile regurgitation, which decreased little by little. One week after operation, the child was considered out of danger.

The pathological report was as follows: "The cystic formation was filled with a clear yellow fluid and there

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was no communication between the duodenum and the cyst. The interior surface of the cyst is lined with a mucosa of duodenal type."

Seen in February 1956, the baby was doing well and his physical development was normal; he had absolutely no digestive trouble.

ILEAL ATRESIA

A male baby, born at 4.00 a.m. on August 5, 1955, was sent to hospital on August 6, at 8.00 p.m., for vomiting since birth. The baby was premature (7 months) and weighed 4 lb. 10 oz. At home, he had had only one bowel motion, by enema, and his physician noted that the stools were very small in quantity and rather hard.

During examination by the pædiatrician, he vomited two or three times, and vomitus contained bile; the abdomen was markedly distended and painful. The general condition was very poor; rectal temperature 98.3° F.

A radiograph taken immediately showed a large amount of gas in the stomach and upper small bowel with fluid levels; no gas was found in the colon. A diagnosis of obstruction of the distal part of the small bowel was made and immediate operation decided on.

Before the beginning of the operation, a cannula was inserted by cut down into an ankle vein of the right foot and glucose-saline solution was given; an inlying gastric tube was also introduced.

Incision was through the right rectus above and below the umbilicus; the following was the situation (shown in Fig. 2). The upper and lower left abdomen was filled with distended intestinal loops ending blindly near the right lobe of the liver and fixed to the anterior abdominal wall. About two inches (5 cm.) lower, but free in the peritoneal cavity (except for its mesentery), lay the distal end continuing with twisted loops of bowel to the cæcum; this intestinal portion was much like a spiral spring. No other anomaly was found.

To untwist these collapsed loops, it was necessary to cut the corresponding mesentery, thus necessitating an intestinal resection. Along with the terminal ileum, we had to remove the appendix, the cæcum and a small part of the ascending colon on account of poor vascularization; a termino-terminal anastomosis between the ascending colon and the opened proximal end of the ileum was accomplished in two layers. The colon was absolutely normal in appearance and on palpation.

The abdomen was closed in three layers without drainage; the operation, which lasted one hour and 45 minutes and during which 100 c.c. of whole blood was transfused, was well tolerated.

Parenteral fluids were continued during 36 hours, after which, the gastric tube being closed from time to time, the infant was given water orally. The gastric tube was finally removed 12 hours later, and feeding with milk and water began thereafter. The bowels had moved earlier in the day. During the following ten days, recovery was considered normal for such a case.

The length of bowel removed was 24 cm. and no pathological lesion was found on examination.

Then began a series of complications, both serious and benign. The first and the longest one was a tenacious diarrhœa which the pædiatrician (J.M.C.) had much difficulty in stopping. Twice during the first six weeks after the operation, we had to remove fragments of unabsorbed catgut stitches from the wound. In the seventh postoperative week, an abscess of the right thigh was opened and drained; the cause of this was probably contamination through erythematous lesions of the anal, genital and inguinal regions.

In the middle of November, everything seemed all right and the parents were told to take their child back home; they did not come and this proved fortunate because, one week later, the baby developed a bilateral bronchopneumonia. Again, the pædiatrician proved equal to the occasion and saved the child, who was left by his parents in hospital until January 15, 1956. On his departure, his weight was 8 lb. 3 oz.

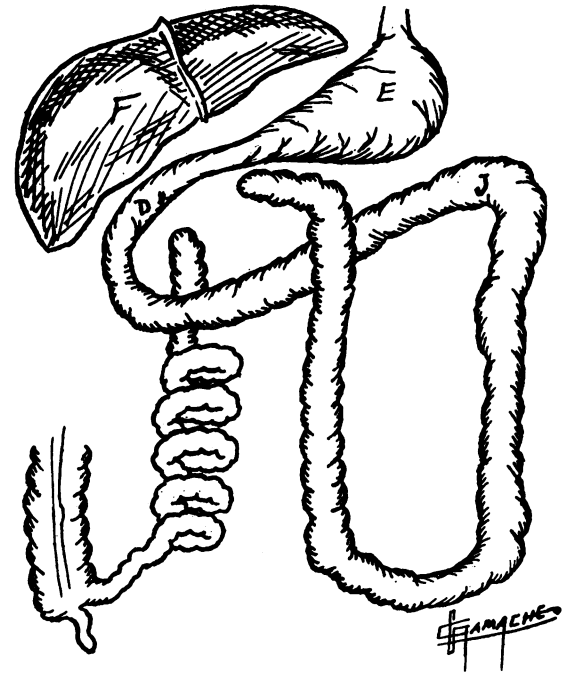

Fig. 2.—Ileal atresia; the distal end of the ileum was in front of the duodenum and not behind, as in the drawing.

COMMENTS

1. One of us (J.L.) has previously reported (*Canad. M. A. J.*, 70: 187, 1954) a case of congenital microcolon, with malrotation of the colon and multiple atresia of the small bowel. The existence of congenital microcolon was called in question by a critic who urged that if the colon was so small it was on account of the atresia higher up and the impossibility therefore of its dilation by meconium. We have proof in the case reported above that this idea was false. In the present case of ileal atresia, the colon was absolutely normal in appearance although nothing was passing through it from above; the colon was at least three times as big as the one in the case of congenital microcolon, and its consistency was softer than the other one.

2. In cases of duodenal duplication, we think that, when it is feasible, resection of the duplication along with the adjacent duodenum is superior to cutting a window between the cyst and adjacent duodenum, as advocated by Gardner and Hart.

With a window, there is always the danger of trapping duodenal contents in the pouch and also that the window may become too narrow or occluded and the cyst re-form.