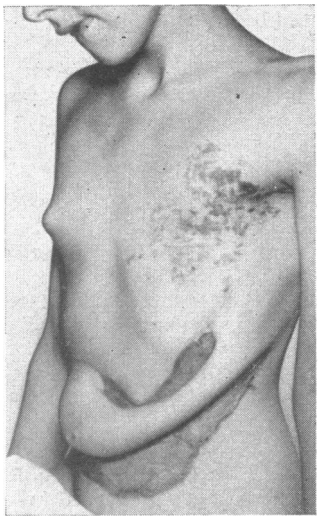

FIG. 9A (*Case IV*).—Radionecrosis, pedicle prepared.

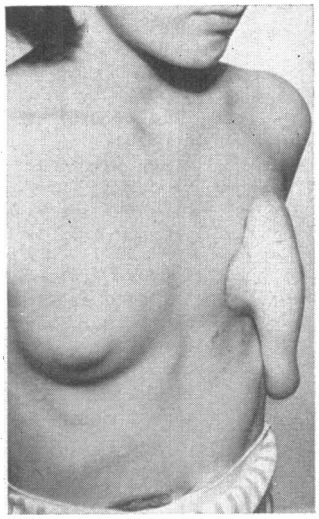

FIG. 9B (*Case IV*).—Implantation after excision.

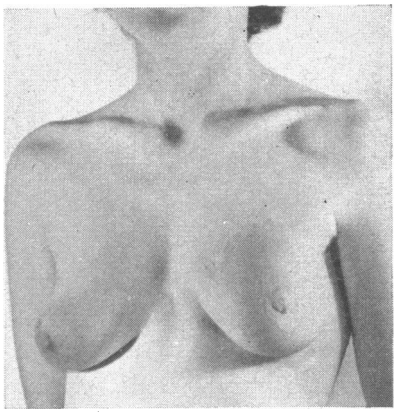

FIG. 10 (*Case IV*).—Left breast reconstructed. Right breast ptosed after lactation.

Holdsworth, A. J. Evans, Douglas Reid, Halfdan Schjelderup, and many others; to Miss Patricia Archer for the diagrams and to Mr. C. B. Ferrill and Miss N. Walker for their care in the photography of these cases.

Figs. 7A, B and C, and 8A and B are reproduced from Gillies and Millard (1957) by kind permission.

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For further references *see* Marino (1958).

New Operation for Rectal Prolapse

By Professor CHARLES WELLS, F.R.C.S.

Liverpool

I HAVE traced in the literature between 30 and 50 operations for prolapse of the rectum and would like to add still one more.

Rectosigmoidectomy, the most frequently practised procedure, is followed by relapse in half the cases and by some incontinence in three-quarters of all cases (Thompson, 1950).

True prolapse of the rectum is associated with atrophy of the supporting muscles and ligaments in the pelvis. When the abdomen is opened, the pelvis appears enlarged and empty. The prolapse is only part of a massive sliding hernia in which the peritoneal sac is formed by the recto-vesical pouch or by the pouch of Douglas. The rectum is abnormally mobile on a long mesentery. As with all hernia operations, a good result depends upon the soundness of the repair and peritoneal suture alone is not enough. Attempts have therefore been made to repair the pelvic fascia by direct suture as described by Graham (1942), Goligher (1958) and others. The operation is a difficult one and I have fallen back upon the use of a prosthesis.

Polyvinyl alcohol sponge (Ivalon) was tried out in the dog by my lecturer Theo Schofield at the Mayo Foundation. This substance becomes incorporated into the tissues in which it excites a vigorous fibrotic response, with the production of a firm, almost cartilaginous, mass. I am told that it proved a failure in mammoplasty because it produced, almost literally, marble busts. In the early cases I made a complete tunnel of

Ivalon on the front of the sacrum. We had no trouble, but I became nervous about intestinal obstruction and changed over to an open trough (Fig. 1), which is in any case easier to place in position.

We have done this operation fifteen times—the first five years ago. About half were recurrent cases. The prolapse has been well controlled in every case and all are continent. In two or three women over 70 in whom a separate repair of a vaginal prolapse did not seem justifiable, the standard procedure was carried out for the rectal condition with unexpected and complete relief of the vaginal prolapse as an incidental result. In one patient the abdomen was reopened for another reason several weeks after the repair and complete peritoneal cover of the sponge was observed with no overlying adhesions.

Technique.—The peritoneum on either side of the meso-rectum is reflected laterally as a flap, and the rectum with its superior rectal vessels is lifted forwards from the hollow of the sacrum. The dissection is carried forwards and downwards between the rectum and prostate (or vagina) for about a further 2 in. (5 cm.). A sheet of Ivalon is now attached to the anterior surface of the sacrum between the promontory and the third or fourth segment, by three midline sutures of thread. The rectum is then drawn firmly upwards and the Ivalon folded around it to enclose all save the anterior fourth or fifth of its circumference. The Ivalon is attached to the rectum by sutures along the anterior free edge of the sponge. Finally the flaps of peritoneum are replaced to cover the operative field.

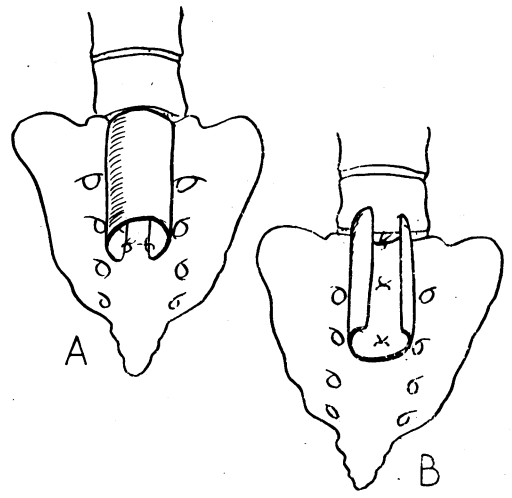

FIG. 1.—A, Sketch of Ivalon sponge attached by its free margins to the hollow of the sacrum to form a tunnel. B, Sketch of Ivalon sponge attached to the hollow of the sacrum to form a trough.

(The technique of the operation was illustrated by a cine-film.)

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A Brief Review of Dissecting Aneurysm of the Aorta and a Report of the Successful Treatment of a Case

By A. B. BIRT, F.R.C.S.

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DISSECTING aneurysm of the aorta has been recognized at autopsy for just over a hundred and fifty years, but it was not until 100 years ago that the first case was correctly diagnosed during life. Shennan of Aberdeen in 1934 in a review of 300 cases from the world literature in the seventy-eight years from 1855 to 1933 found that only 1·6% had been diagnosed before death; but in 1950, Levinson *et al.* reported a series in which 10·6% had been diagnosed during life. The first operative attack on a dissecting aneurysm of the aorta was reported by Gurin *et al.* in 1935, the patient dying of renal failure on the sixth post-operative day. Since then an increasing number of cases has been operated upon, at first without survival for more than a few days, but more recently with an increasing success. As far as I can ascertain from the world literature there have been 13 successful cases reported: 10 by Creech *et al.* (1956), one by Warren *et al.* (1956) and one by Swann and Bradsher (1956). All these cases were in the United States of America. There is one case from this country (Martin and Muir, 1958) in which operation was temporarily successful but the patient unfortunately died about eight months after operation from rupture of the aneurysmal sac into the pericardium. To these I should like to add my own case of a patient who was operated upon on November 4, 1956, and is still alive and well.

Increased success in surgical treatment entirely depends upon more accurate diagnosis and this will only be achieved if the possible presence of the lesion is always kept well in mind. The tear in the media from which the dissection originates is most commonly situated in the ascending