SELECTED ABSTRACTS

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Comparison of transhiatal and transthoracic oesophagectomy with three field lymphadenectomy

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Introduction
Oesophageal resection for carcinoma may be carried out by either the transhiatal (TH) or transthoracic (TT) technique with radical lymphadenectomy. The aim of this study was to compare clinico-pathological data and short term outcome.

Methods
42 patients with cancer of the oesophagus were studied. The tumours in 15 patients were resected by transhiatal oesophagectomy and 21 by transthoracic oesophagectomy with three field lymphadenectomy.

Results
Mean age in the transhiatal group was 57 years while it was 58 in the transthoracic group. Male to female ratio was 2:1 in transhiatal and 3:4 in the other group. Mean tumour location was at 32.4cm in the transhiatal group as opposed to 31cm in the transthoracic group. Neoadjuvant cisplatin based chemoradiotherapy was given to 25/36(70%) of all patients. Lymph node yield ranged from 2-15 (mean 6) in the TH group while in the TT group, it ranged from 26-48 (mean 35). 25% of patients in the TH group had positive nodes of whom only one received adjuvant chemotherapy while 50% of the TT group had positive lymph nodes. Mortality in the TH group was one while in the TT group it was four. Anastomotic leak was seen in two of the 21 TT group and none in the TH group.

Conclusions
Lymph node yield in a transthoracic oesophagectomy is significantly high compared to transhiatal approach (P<0.001). A systematic lymph node clearance is prognostically favourable as there is limited adjuvant therapy on offer. Three field oesophagectomy offers a more complete lymph node clearance.

Do brachiocephalics do better? a comparison with brachiobasilic arteriovenous fistulae

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Introduction
2006 Kidney Decease Outcomes Quality Initiative (KDOQI) guidelines recommend that the order of preference for arteriovenous fistula (AVF) placement is radio-cephalic, brachio cephalic (BC) and, then brachio basilica (BB). Majority of the fistulae constructed in our unit were cubital fistulae. We compared outcome of BC vs BB AVFs.

Methods
The study included consecutive consenting patients who underwent construction of cubital fistulae based on sonographic assessment. They were evaluated clinically and sonographically. The results were compared using chi square and independent samples tests.

Results
In the 125 patients 136 AVFs were constructed of which 105 (77.20%) were brachio cephalic and 31 (22.79%) brachio Basilica. Median age was 50 (18-78) in the BC group and 49.5 (18-81) in the other. Gender distribution was equal with 52 (49.52%) males in BC and 16 (51.61%) in BB groups. Mean follow up was 14 (1-24) months in BB and 12.65 (1-24) in BC group. Mean time to first puncture was 92 (1-324) days in BB (p>0.05). Mean flow rates during the first hemodialysis were 183.89ml/min (150-300) in BC group and 181.67ml/min (150-250) in BB group (P>0.05). BC group had a larger mean venous diameter [8.77 mm (3.3-16.2)] than BB group [5.38 mm (2.6-7.3)]; 4cm s above the AVF (p<0.05).

Brachio basilic procedures had a higher complication rate [16(51.61%)] than brachio cephalic procedure [41(39.04%)] (p>0.05). 24 (22.85%) BC fistulae and 1(3.22%) BB fistula have failed (p<0.05).

Conclusions
Brachio basilica fistulae have a lower failure rate than brachio cephalic fistulae according to our study.

Donor evaluation for liver transplantation - one year results

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Introduction
Liver Transplantation (LT) is the treatment of choice for end stage liver diseases. Lack of suitable organ donors is a major challenge faced by centers around the world.

Methods
The study population included the potential live and cadaveric

donors evaluated for liver transplantation by the Colombo North Liver Transplantation Service (CNLTS). All data were collected prospectively.

Results
33 donors were evaluated over a period of one year including 17 live and 16 cadaveric donors. Of these eight transplants were performed.

Out of 17 live donors evaluated 12 (70.6%) were male. Mean age was 39.41 years (27-57 years). For one recipient a mean of 1.54 donors (1-4) were evaluated. Only 17.6% (3/17) proceeded to organ donation, majority of the donors (52.9%-9/17) were unrelated. Common cause for refusal was poor liver profile (41.6%-5/12). Only 35.7%% (5/14) proceeded to final stage of evaluation with imaging.
Of the 16 cadaveric donors 12 (75%) were male. Mean age was 42.68 years (18-65 years).
Common cause of death was road traffic accidents (75%, P=0.001). Five donors (31.25%) proceeded to organ donation and commonest cause for failure in organ retrieval was inability to get the consent from the relatives (72.72%, p=0.001).

Conclusions
Finding a matching living donor for LT is as difficult as finding cadaveric donors. Awareness of organ donation needs to be increased in the public to facilitate cadaveric organ donors.

Duodenal diverticuli: do they predispose for common bile duct (CBD) pathology?

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Introduction
Periampullary duodenal diverticuli (PDD) are extra luminal mucosal out pouching of duodenum arising adjacent to or containing the ampulla of Vater or intraluminal portion of CBD. Juxta-papillary duodenal divericuli (JDPP) are defined as diverticuli located within a radius of 2cm of major papilla but not involving them. We note that patients with DD have a higher tendency for stone formation and biliary complications.

Methods
100 consecutive patients who underwent ERCP at the National Hospital Sri Lanka in 2011 were included in this study. The incidence of DD, position, associated pathology, difficulty index special procedures, outcome and complications were noted.

Results
26 patients had DD. 18 had PDD and six JPDD. 12/18 of PDD and 4/6 JPDD had common bile duct stones. 1/26 an ERCP could not be performed and had opened CBD exploration. In 6/18 with PDD a Hurricane balloon dialation of the papilla was done instead of sphincterrotomy. There was one hilarcholangio cancer and two pancreatic cancers and four pancreatitis patients. Patients with stone disease were managed with total endoscopic procedures in 23/24.

Conclusions
Patients with PDD and JPDD have a high incidence of CBD stones disease. A papillary manometry study could be undertaken to ascertain the biliary sphincter pressures in patients with PDD.

Ejaculation preserving transurethral resection of prostate: A pilot study

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Introduction
Retrograde ejaculation is the commonest morbidity following TURP. Most sexually active men undergoing TURP prefer to have their ejaculation preserved.

Objective
To assess the feasibility of "Ejaculation Preserving TURP" technique and evaluate short term outcome.

Methods
We assessed 15 sexually active males aged 51-60 (mean-58.5) undergoing Ejaculation Preserving TURP. Mean prostatic volume was 37.6ml (range 12-59ml). Bipolar TURP, resecting adenoma at bladder neck including median lobe and prostatic urethra performed. Two small cushions of adenoma and mucosa at the prostatic apex and a few millimeters of prostatic urethral mucosa just above the veru montanum was preserved. "Flap valves" were not created. "Ejaculation Projection Score" was used to assess projection during ejaculation following procedure. Patients were assessed pre-operatively, at six weeks, three, six and 12 months

Results
Mean maximum flow rates improved from 6.3ml/S to 22ml/S, residual volumes from 120ml - 34ml. IPSS scores from 25 - 5.8 and quality of life scores from 5.2- 1.2. Ejaculatory function remained un-changed from 4- 3.5(p=0.02) and "Ejaculation

Projection Score" from 3.3 - 3.1(p=0.57). IIEF score remained unchanged. 12/15 had no change or improved ejaculation following surgery and cessation of medical therapy, denoting a success rate of 80%. 1/15 had complete loss of ejaculation while 2/15 had reduced ejaculation

Conclusions
Our success with various sized adenomas implies satisfactory degree of unblocking of the outflow with this technique whilst preserving antegrade ejaculation.

Pre-operative hypoalbunaemia is associated with poor overall survival in rectal cancer

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Introduction
Serum albumin is a marker of nutrition and inflammation. It has recently emerged as a predictor of outcome after surgery for rectal cancer. Our aim was to evaluate if pre-operative serum albumin would predict survival after resection for rectal cancer.

Methods
226 patients with rectal cancer of all stages undergoing resection with curative intent were studied. Kaplan-Meier curves analysed survival based on a pre-operative albumin level of <35g/Lvs. >35gL. We sought for significant associations of survival with age, sex, stage, tumor site, use of neoadjuvant chemoradiation, microscopic positive resection margins (R1), differentiation, angio, peri-neural and lymphovascular invasionusing individual variable analysis. Multifactorial analysis was performed using type 111 analysis with Weibull hazard model and Cox-proportional hazard model. Significance was assigned to a P value <0.05.

Results
Out of 226 patients (median age 59 years; range 19-88, male-54%). 45 (20%) had an albumin level <35g/L and was associated with a poor overall survival (P=0.01). Mean survival in months for <35g/L vs >35g/L was 64.7 (SE-9.3) vs. 95.8 (SE-7.0). Individual variable analysis revealed age, circumferential margin, stage, perineural, lymphovascular and angio invasion to be also significant with multifactorial analysis hypo-albunaemia (HR=0.58, P=0.03), advanced stage (HR=2.0, P< 0.01) and R1 circumferential margin (HR=2.2, P<0.01) remained significant.

Conclusion
Preoperative hypoalbunaemia is an independent risk factor for poor overall survival in rectal cancer. Advanced tumor stage and R1 circumferential margin were the other associations with poor survival.

Quality of life after kidney donation; the first Sri Lankan follow-up

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Introduction
Live donor kidney donation remains the predominant source of organs for kidney transplantations in Sri Lanka. Therefore preservation of Quality of Life (QoL) of kidney donors remains mandatory.

Methods
We compared the QoL of 42 live kidney donors with that of age, sex matched healthy non kidney donor sample. Nottingham Health Profile (NHP) was used. NHP consists of six domains which are, Energy Level (EL), Pain (P), Emotional Reaction (ER), Sleep (S), Social Isolation (SI) and Physical Abilities (PA). Each component is scored out of 100 and a higher score indicates a poor QoL. In addition we analysed post nephrectomy surgical complications.

Results
50% of the donor population was males with a median age of 44 years (25-64). 62% (n=26) were related donors. The overall surgical morbidity was 26.2 and (n=10). Six (14%) complained of minor pain at the site of incision. Three (7.1%) had surgical site infection while I was re-operated for bleeding. Incissional hernia (n=1) and LRTI (n=1) were the other significant post-operative complications. The mean time to return to normal activity was 11 weeks (2-56). The mean scores obtained by the donor population for each QoL domain were EL=13.58, P=14.59, ER=18.95, S=12.45, S1-14.24, PA=5.00. The mean scores of the comparison group were as follows: EL=12.07, P=4.64, ER+16.46, S=19.12, SI=18.22, PA=5.00. The difference in mean scores between the two groups was not statistically significant. (All p.0.05)
The QoL in the donor population is comparable to that of the non-donor healthy control group. The prolong duration to get back to normal activity after open donor nephrectomy suggests