

Pelvic Sepsis after Stapled Hemorrhoidectomy

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I read with interest the article, "Pelvic Sepsis after Stapled Hemorrhoidectomy" by Pessaux and colleagues,¹ but was surprised that there was no comment on the HIV status of their patient, a known homosexual. It is indeed debatable whether anoreceptive sexual intercourse is the precipitating factor in Dr Pessaux's patient; surely it is more likely to be HIV disease? In Africa, where HIV disease is sadly all too common, it is well understood that hemorrhoidectomy by whatever method is fraught with complications in HIV patients, the risk being greater the lower the CD4 count.²⁻⁴ Fournier's gangrene is such a well-known complication, as it is after circumcision or hernia repair. Current recommendations are to avoid surgical intervention for hemorrhoids and to treat by injection of oily phenol.⁵ If hemorrhoids are prolapsed and irreducible, they can be shrunk by the application of icing or castor sugar.

REFERENCES

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Reply

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We thank Dr Cotton for his constructive comments about our image. In fact, we forgot to specify the HIV

status of the 44-year-old homosexual man. The HIV serology was negative twice controlled. We also agree with current recommendation to avoid surgical treatment of hemorrhoids in HIV patients with low CD4 count.

Laparoscopic Approach for the Treatment of Type II Gastroesophageal Junction Tumors

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We read with great interest the article by Hiromichi and colleagues¹ in the December 2004 issue about the optimal surgical approach to gastric cardia adenocarcinoma. The authors reported their very impressive experience with 82 patients with type II or type III gastroesophageal junction tumors and submitted to total esophagectomy or to extended proximal gastrectomy, with or without thoracotomy. Mortality and morbidity rates were 2.4% and 20%, respectively (morbidity rate was 33% after total esophagectomy and 11% after proximal gastrectomy with or without thoracotomy).

The authors raised two important problems: the difficulty in obtaining a radical surgical resection (R0) that requires a gross proximal resection margin length of at least 6 cm and a distal resection margin length of at least 4 cm, and the importance of obtaining and analyzing more than 15 lymph nodes to allow for valid N staging.

We would like to report our experience on the laparoscopic treatment of type II gastroesophageal junction tumors. From 1999 to 2004, we operated on five patients (four men and one woman, mean age 79.2 ± 4.5 years). We performed a total esophagectomy plus proximal gastrectomy with gastric transhiatal tubulization and cervical gastroesophageal anastomosis in four patients and a partial esophagectomy plus proximal gastrectomy with transhiatal tubulization of the stomach

and intrathoracic gastroesophageal anastomosis in one patient. All resections were R0, with a proximal margin length larger than 6 cm and a distal one larger than 4 cm. The mean number of harvested lymph nodes was 18 ± 7.4 , and only one patient had less than 15 lymph nodes. The mean number of positive lymph nodes was 6.4 ± 5.5 ; only one patient had no positive lymph nodes. Tumor stage was II in three patients and III in two patients. Grading was 3 in three patients and 2 in two.

The conversion and mortality rates were 0%. Major postoperative morbidity occurred in one patient (20.0%) and consisted of a cervical anastomotic leak that was conservatively treated and healed after 28 days. Minor postoperative morbidity occurred in one patient (20.0%), who had a bilateral pleural effusion that was

surgically evacuated. Three patients died from neoplastic distant recurrences after 8, 35, and 42 months. One patient died after 48 months of cardiac failure without cancer recurrence. One patient is alive 2 months after the operation.

We conclude that total laparoscopic treatment of this type of gastroesophageal junction tumor could represent a safe and valid alternative to the conventional open approach, allowing a radical resection and a satisfactory lymphadenectomy, but avoiding a thoracotomy.

REFERENCE

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