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**Laparoscopic nissen-rossetti fundoplication with routine use of intraoperative endoscopy and manometry: technical aspects of a standardized technique.**

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BACKGROUND: Several different ways of fashioning a total fundoplication lead to different outcomes. This article addresses the technical details of the antireflux technique we adopted without modifications for all patients with GERD beginning in 1972. In particular it aims to discuss the relation between the mechanism of function of the wrap and the physiology of the esophagus. **METHODS:** The study population consisted of 380 patients affected by GERD with a 1-year minimum of follow-up who underwent laparoscopic Nissen-Rossetti fundoplication by a single surgeon. **RESULTS:** No conversion to open surgery and no mortality occurred. Major complications occurred in 4 patients (1.1%). Follow-up (median 83 months; range: 1-13 years) was achieved in 96% of the patients. Ninety-two percent of the

patients were satisfied with the results of the procedure and would undergo the same operation again. Postoperative dysphagia occurred in 3.5% of the patients, and recurrent heartburn was observed in 3.8%. **CONCLUSIONS:** Laparoscopic Nissen-Rossetti fundoplication with the routine use of intraoperative manometry and endoscopy achieved good outcomes and long-term patient satisfaction with few complications and side-effects. Appropriate preoperative investigation and a correct surgical technique are important in securing these results.

An Evidence-based Approach to Familial Nonmedullary Thyroid Cancer: Screening, Clinical Management, and Follow-up.

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Approximately 5% of nonmedullary thyroid cancers are of familial origin. When two or more family members are diagnosed with nonmedullary thyroid cancer in the absence of other known associated syndromes it is termed familial nonmedullary thyroid cancer (FNMTc). The genetic inheritance of FNMTc remains unknown, but it is believed to be an autosomal dominant mode of inheritance with incomplete penetrance and variable expressivity. FNMTc has been shown to be more aggressive and to have a worse prognosis than sporadic nonmedullary thyroid cancer. For example, studies have demonstrated that individuals with FNMTc have an increased risk of multifocal disease, local invasion, and lymph node metastases. These aggressive features appear to contribute to the higher recurrence rate and decreased disease-free survival seen in FNMTc patients compared to those with sporadic differentiated thyroid cancer. This article is an overview of the literature available in the English language discussing FNMTc. Critical questions regarding the screening, management, and follow-up of these patients are addressed with answers proposed based on the available literature. The quality of the evidence is ranked according to Sackett's criteria. Overall, the literature quality is somewhat limited, based on the low prevalence of FNMTc, the difficulty in identifying familial cases, the variable study designs, and limited long-term follow-up. **Conclusions:** To date, the optimal clinical approach is yet to be established, but improved awareness and screening will permit earlier detection, more timely intervention, and hopefully improved outcomes for patients and their families.

7201 carcinoids: increasing incidence overall and disproportionate mortality in the elderly.

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INTRODUCTION: The aim of the study was to determine outcomes for respiratory and gastrointestinal carcinoid tumors utilizing a large cancer registry. **METHODS:** Cases of respiratory and gastrointestinal carcinoid from the Florida Cancer Data System (FCDS) from 1981 to 2001 were reviewed. Descriptive statistics, age-adjusted tumor incidence, and survival rates were determined. **RESULTS:** A total of 7201 cases of malignant carcinoid were identified. Pulmonary and gastrointestinal carcinoid tumors comprised 82% of all carcinoids encountered. The mean age was 64.4 +/- 0.15 years. Stratified by location, there were 3000 (51.4%) foregut carcinoids (including those found in the respiratory tree-2325 in the lung), 2130 (36.5%) midgut carcinoids, and 712 (12.2%) hindgut carcinoids. Second, distinct malignancies were observed in 23% of cases. The total age-adjusted incidence rate has increased from 0.62 per 100,000 in 1980 to 5.17 per 100,000 in 2000. Overall median survival was 21.97 months. The median survival was 19.0 months for foregut carcinoids (excluding those arising in the respiratory tract); 33.9 months for midgut tumors; and 22.7 months for hindgut carcinoids. There was a statistically significant better survival for those with midgut tumors than for those in the other groups ($P < 0.001$). Age < 60 years, white race, and female sex were all associated with better survival ($P < 0.01$). **CONCLUSIONS:** The incidence of pulmonary and gastrointestinal carcinoids has dramatically increased since 1981. Tumor location and age ≥ 60 years are the strongest predictors of mortality.

Coagulopathy: its pathophysiology and treatment in the injured patient.

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Hemorrhage continues to be one of the leading causes of death following trauma. Trauma patients are susceptible to the early development of coagulopathy and the most severely injured patients are coagulopathic on hospital admission. Hypothermia, acidosis, and dilution from standard resuscitation can worsen the presenting coagulopathy and perpetuate bleeding. Early identification of coagulopathy is dependent on clinical awareness and point of care laboratory values. Routinely used laboratory coagulation parameters fail to adequately describe this state. Thrombelastography is a test that can be done at the bedside and uses whole blood to provide a functional evaluation of coagulation. Rapid diagnosis of coagulopathy, followed by prevention or correction of hypothermia and acidosis should be a priority during the initial evaluation and resuscitation. Judicious use of resuscitation fluids and early replacement of coagulation factors will help prevent iatrogenic hemodilution. This review covers the pathophysiology as well as the clinical and laboratory diagnosis of coagulopathy. Prevention and treatment strategies are discussed, including early transfusion of coagulation factors during massive transfusion and the use of recombinant factor VIIa. Damage control resuscitation is briefly discussed, and it involves the combination of hypotensive resuscitation and hemostatic resuscitation. Finally, a description of the use of fresh whole blood in the military setting is included. Its use has been proven to be safe and beneficial in this setting and warrants further investigation as an adjunct to the management of civilian trauma patients.

A Single Surgical Unit's Experience with Abdominal Tuberculosis in the HIV/AIDS Era.

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INTRODUCTION: Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) has resulted in a resurgence of abdominal tuberculosis in South Africa, and these patients often present to general surgeons. We describe a single-hospital experience in a region of high HIV prevalence. **METHODS:** A prospective database of all patients with suspected abdominal tuberculosis was maintained from January 2003 until July 2005. **RESULTS:** There were 67 patients (20 men, 47 women) with an average age of 32 years (range 27-61 years). The erythrocyte sedimentation rate was universally elevated (105 +/- 23). Altogether, 23 patients were HIV-positive and 7 were HIV-negative. The status was unknown in the remainder. Chest radiographs demonstrated an abnormality in 17 patients (22%). Abdominal ultrasonography was performed in 59 patients and computed tomography in 12. Twelve laparotomies were performed, seven as emergencies. None in the elective laparotomy group died, whereas the mortality rate in the emergency group was 60%. Laparoscopy was insufficient for a variety of reasons. Two patients underwent appendectomy and two excision of a perianal

fistula. Two patients underwent biopsy of a palpable subcutaneous node, which confirmed the diagnosis in both cases. A definitive diagnosis was achieved in all 12 patients subjected to laparotomy and at colonoscopic biopsy in 2, lymph node biopsy in 2, appendectomy in 2, perianal fistulectomy in 2, and percutaneous drainage in 2. In the remaining 47 patients the diagnosis was made on the basis of the clinical presentation and radiologic imaging. The patients were commenced on antituberculous therapy. The in-hospital mortality in this group was 10%. Therapy was continued at a centralized tuberculosis facility independent of the hospital. Surgical follow-up was poor, with only five (7%) patients completing the 6-month review at a surgical clinic. CONCLUSIONS: A resurgence in tuberculosis during the HIV era produces a new spectrum of presentations for the surgeon. Emergency surgery is associated with high mortality. Bacterial and histologic evidence of infection are difficult to obtain, and indirect clinical and imaging evidence are used to commence a trial of therapy. A short-term clinical response is regarded as proof of disease. Lack of follow-up means that the efficacy of this strategy is unproven. Health policy changes are needed to enable appropriate surgical follow-up to determine the most effective management algorithm.