

Introduction

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Oesophageal Surgery

The great majority of oesophageal resections are performed because of malignant disease. Because of advances in surgical technique and perioperative care, hospital mortality after oesophageal resection has decreased over the last decades from 29% in the period 1953–1978 to 7.5% in the period 1990–2000. Several studies have shown that centralization of oesophagectomies in dedicated centres might help to decrease hospital mortality [1]. The experience of the surgeon is a major factor influencing mortality rates after oesophagectomies.

Oesophageal resection implies a great surgical trauma in at least two (chest and abdomen) and frequently even three (chest, abdomen and neck) different compartments. Especially the combination of a thoracotomy and a laparotomy puts the patient at great risk for the development of serious postoperative (especially cardiopulmonary) complications. The transhiatal resectional technique has been developed to limit the surgical trauma, but has been criticised because of its supposedly limited oncological radicality.

Most surgeons consider the narrow gastric tube as the preferred organ for reconstruction. The oesophago-gastric anastomosis can be made either in the neck or in the chest. On the one hand, a cervical anastomosis has a rela-

tively high risk of leakage and benign stricture formation. On the other hand, a cervical dehiscence only rarely leads to a life-threatening mediastinitis, which is in contrast to an intrathoracic anastomosis.

Many different anastomotic techniques have been tested, including end-to-end versus end-to-side anastomosis, hand-sewn versus mechanical suturing, running versus interrupted suturing. Recently, it has been claimed that a side-to-side anastomosis has excellent outcome, with low leakage rate and low stricturing rate [2].

In this postgraduate course a patient was presented who developed severe postoperative complications due to delayed healing of a cervical anastomosis following oesophageal resection. Subsequently, a comprehensive review of the recent literature was presented by Prof. Lerut (Leuven, Belgium).

Gastric Surgery

Peptic ulcer hemorrhage (PUH) remains an important medical emergency. Mortality is still substantial and has remained stable over the past few decades, despite advances in diagnosis and therapy. During this period, the role of surgery in the management of PUH has dramatically changed. Endoscopic therapy has superseded surgery

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as the first-line method to stop ulcer bleeding. Nowadays, the aim of surgery is mostly confined to situations in which endoscopic therapy fails [3].

Adequate hemostasis can be obtained in more than 98% of the patients by experienced endoscopists [4]. This

leads to a highly negative selection of the most complicated patients for surgical intervention. The optimal timing of operation and choice of surgical techniques remain the great challenges in today's surgical management of patients with PUH.

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