kinking of the esophagocardiac junction as the etiopathogenesis, and that atresia represents the extreme outcome. They also point out that further studies of the pathogenesis are required—*Prem Puri*

Membranous Atresia of the Lower Oesophagus. *S.C. Gopal, A.N. Gangopadhyay, S.K. Pandit, et al.* Pediatr Surg Int 8:140-141, (February), 1993.

A rare case of membranous esophageal atresia in the lower esophagus is described. This was managed by an abdominal approach. The lower esophagus was mobilized as usual. A gastrotomy was performed and the membrane excised after it was pushed down by a transoral gum elastic bougie. The esophageal muscular wall was continuous. A Thal procedure was performed to prevent reflux.—*P. Puri*

Conservative Treatment of Corrosive Esophageal Strictures: A Comparative Study of Endoscopic Dilatations and Esophageal Stenting. *F. De Peppo, M. Rivosecchi, G. Federici, et al.* Pediatr Surg Int 8:2-7, (January), 1993.

The authors present their experience with corrosive esophageal injuries over a 9-year period. Of 222 patients, 126 patients were noted to have esophageal injuries on endoscopy. Eighteen children proceeded to develop esophageal strictures. Four were treated surgically. Of the remaining 14, seven patients before 1987 were treated with periodic esophageal dilatations, and seven since 1988 were treated with esophageal stents. The latter patients also received steroids, antibiotics, and H_2-blockers. Although this is not a prospective randomized controlled study, the authors showed that esophageal stents reduced the number of dilatations required as well as duration of treatment. They also emphasize the importance of treating gastroesophageal reflux (GER) in these patients surgically to achieve faster healing. It is suggested that these patients are more prone to GER because of stricture, scarring, and narrowing of esophagus.—*Prem Puri*

Treatment of Esophageal Caustic Injuries: Experience With High-Dose Dexamethasone. *S. Cadranel, M. Scaillon, P. Goyens, et al.* Pediatr Surg Int 8:97-102, (February), 1993.

The authors compare the results of high-dose dexamethasone (1 mg/kg daily for 4 to 6 weeks) and fine silicone nasogastric tubes (6F to 8F) (protocol C) with previously used protocols using prednisolone (2 mg/kg daily) with fine silicone nasogastric tube (protocol A) and prednisolone with a wide silicone stent (12F to 18F) (protocol B). Group C consisted of heterogenous group of 9 patients, including 4 children who were initially treated according to scheme A or B but had unsatisfactory results. All patients in group A had III+ lesions (extended mucosal ulcerations, white plaques, and sloughing of the mucosa in a circumferential pattern) and required multiple dilatations (13-33). Group B included 7 patients: 1 with II+, 5 with III, and 1 with III+ lesions. Group C included 9 patients: 5 with II+ lesions have no strictures while of 4 patients with III+ lesions, one was operated elsewhere, one patient has a stricture, and one patient is still active. Data are not provided with regard to what percentage of patients from each category proceeded to develop strictures. The authors state that there was a dramatic reduction in the number of dilatations in some children from group B with introduction of high-dose dexamethasone. Five of the 9 patients in group C developed dexamethasone associated complications: infection (3), prepyloric ulceration (1), and osteoporosis (1). The authors believe that patients with a history of caustic ingestion should receive dexamethasone. However, as they point out, further investigations are required to evaluate the efficacy of high dose dexamethasone in the presence of more serious initial lesions.—*R.H. Surana*

Esophagocoloplasty for Caustic Stricture of the Esophagus: Changing Concepts. *A.F. Bahnassy and I.E. Bassiouny.* Pediatr Surg Int 8:103-108, (February), 1993.

The authors present their experience of esophagocoloplasty in 520 patients over 15 years. The indications for this procedure in patients with caustic strictures included undilatable stricture (287), multiple strictures (115), frequent occlusions of the stricture with solid food (38), failure of repeated dilatations to achieve a normal growth rate (75), and esophageal perforation (5). Temporary tube gastrostomy was performed prior to reconstruction in the majority of the patients to correct any nutritional deficit. The operation was done by two teams. The preferred colonic transplant was the transverse colon and proximal part of descending colon based upon the left colic vessels. In 455 patients simple bypass of the strictured esophagus through a retrosternal tunnel, and in 65 patients simultaneous transhiatal esophagectomy was performed. End-to-end anastomosis of esophagus and colon was changed to end-to-side anastomosis, which the authors believe has resulted in decreased (3.19% from 9.14%) anastomotic leaks. The mortality was 4.42% and due mainly to pneumonia. Early preoperative complications included anastomotic leaks (5.02%), small bowel obstruction (3.27%), pneumothorax (12.41%), and infection (5.76%). Twenty-one (4.2%) patients developed late complications: stenosis at cervical anastomosis (11), redundant colonic segment (9), and gastrocolic reflux with peptic ulcer (1). Two hundred ninety-six patients were available for long-term follow-up (1 to 5 years). Most of the patients were able to swallow and eat a normal diet without limitation, had gained weight, and had a normal life pattern. The authors believe that redundancy of the colon is an avoidable complication and that the lower incidence of peptic ulceration or gastrocolic reflux may be due to routine pyloromyotomy or pyloroplasty.—*R.H. Surana*

Corrosive Strictures of the Oesophagus in Children. *S. Cywes, A.J.W. Millar, H. Rode, et al.* Pediatr Surg Int 8:8-13, (January), 1993.

Of 55 children with corrosive strictures of the esophagus, 22 responded to esophageal dilatations while 33 underwent a bypass procedure. A description of the authors' operative technique for esophageal bypass procedure with isoperistaltic left colonic retrosternal interposition is presented. The mortality in these patients was 15% (5/33). Complications included anastomotic leaks, strictures, and reflux in majority of patients. Suggestions to prevent anastomotic leaks and strictures include preservation of the vascular pedicle, avoidance of torsion and redundancy, meticulous anastomosis, pyloroplasty to avoid gastric stasis, and decompression of the conduit.—*Prem Puri*

Caustic Ingestion in Childhood: Current Treatment Possibilities and Their Complications. *C. Pintus, C. Manzoni, S. Nappo, et al.* Pediatr Surg Int 8:109-112, (February), 1993.

The authors describe their experience of managing 15 children with a history of ingestion of caustic substances over a 5-year period. All patients had esophagogastroduodenoscopy within 12 to 24 hours. Ten patients had esophagitis: 3 grade I, 2 grade II, 5 grade III. Grade II and III patients were treated with broad-spectrum antibiotics, high-potency corticosteroids, and H_2 antagonists. Nasogastric tube was placed for more severe lesions. All five