Generation of Small Bowel Mucosa

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SUMMARY

Following massive bowel resection, the characteristic features of a 'short bowel' syndrome develop. Some patients respond to medical treatment but may succumb later to the effects of deficient absorption. Some surgical procedures devised for delaying transit through the bowel, are mentioned.

The patient lacks absorptive surface of the bowel. Experiments performed on mongrel dogs to produce generation of mucosa and the results obtained, are described. Further experiments were carried out to show that this generated mucosa has absorptive capacity.


The average length of small bowel in an adult is 6·1 m and the length of colon 155 cm, whereas the average length of small bowel at birth in an infant of 50 cm body length is 300 cm and the large bowel 52 cm.

Massive bowel resection has been defined as resection of all but 75 cm of the small bowel in neonates and all but 90 cm in the adult. In the newborn a minimum of 30 cm of small bowel with an intact ileocaecal valve is regarded as necessary for adequate nutrition and growth.
actual gain in weight. This method of treatment, added to the other known medical measures, proved itself of great benefit in one of our cases.

A newborn baby weighing 2 kg had a massive resection of small bowel for multiple atretic segments, leaving him with 17 cm of small bowel. The immediate postoperative course was uncomplicated but he soon developed the characteristic features of short bowel syndrome as described above. Mouth to anus transit time was 3 - 4 minutes. With parenteral hyperalimentation and intravenous supplementation, we were able to manage him for 9 months with a steady gain in weight, before he was able to maintain himself on oral diet alone. He is now 18 months old, weighing 8 kg. and still thriving. The mouth to anus time has increased to 5 - 6 hours. Although he still has some malabsorption, he does not require supplementation for excessive fluid loss. Thus, with energetic medical management and hyperalimentation, we were able to tide this baby over until the compensatory mechanisms in the remaining small bowel and large bowel could eventually correct the massive fluid loss.

In those in whom all the medical measures have failed, several surgical procedures have been tried—all aimed at delaying the transit through the remaining bowel and so allowing a longer period for contact and absorption. These procedures include: (a) vagotomy and pyloroplasty, (b) recirculating small bowel loops, (c) antiperistaltic gastric tubes, (d) reversed small bowel segments (single or paired), and (e) formation of a pouch (Fig. 1). A recirculating loop has been shown to be inadequate.

The pathological changes noticed in cases with massive bowel resections are: an increase in the diameter of the bowel and prolongation of the villi of the mucosa, rather than any appreciable increase in the length of the bowel. What the patient lacks is absorptive surface of the bowel. In an attempt to produce such an increase in the absorptive surface, the following experiments were carried out in dogs and puppies.

**EXPERIMENTAL PROCEDURE**

The dogs were operated upon under pentobarbital anaesthesia. The abdomen was entered through a midline incision and a segment of small bowel was selected. The lumen of the bowel was occluded with bulldog clamps and a longitudinal incision of variable lengths in different dogs was made on the ante-mesenteric border of the segment between the clamps (Fig. 2). The edges of the incised bowel were sutured to the serosal surface of the adjacent loop of bowel, widening the gap in the incised bowel as far as possible. A two-layered anastomosis was effected with interrupted silk sutures. A cross-section of this procedure is depicted in Fig. 3.

The dogs were fed intravenously for 24 hours before starting oral fluids, and gradually over the next 3 days a more solid diet was introduced. Penicillin and streptomycin were given intramuscularly for the first 3 days.
After periods of 1 - 3 months, the dogs were again anaesthetized and the anastomosed segments were resected. Continuity of the bowel was restored by end-to-end anastomosis. The excised bowel was inspected and submitted for histological study.

From these experiments we were able to conclude that the small bowel mucosa does regenerate, thus increasing the mucosal surface area. The next step was to establish whether this new mucosa has absorptive capacity.

In the first instance, biopsy specimens were taken from the generated mucosa and from normal adjacent mucosa of the small bowel, and the disaccharidase activity of these were evaluated. The disaccharidase activity was comparable between the normal mucosa and the generated mucosa. Further evaluation of the absorptive capacity of this generated mucosa was carried out in our laboratories by Dr Margaret Mayell.

Dogs on whom the operation for generating small bowel mucosa, as described above, was performed 6 - 7 months previously were re-operated upon. The donor limb of small bowel was opened along its mesenteric border for several inches to display the whole mucosal surface, with the newly generated mucosa centrally placed (Fig. 6 (a)). The whole of the donor limb was then dissected off the recipient limb round the generated mucosa. The recipient loop of bowel now looked normal except for the patch of mucosa on its serosal surface (Fig. 6 (b)). The donor portion was resected and discarded. The distal end of the limb of small bowel bearing the generated mucosa was closed and folded upon itself and sutured round the margin of the generated mucosa to form an enclosed sac. Bowel continuity was restored by fashioned a Roux en Y anastomosis and the abdomen was closed in layers (Fig. 6 (c) and (d)).

Isotope studies - Fe and Ca^+

Fig. 6. (a - d). Steps of procedure performed to study absorption of iron and calcium.

The area of the generated mucosa in these dogs measured 5 - 6 cm by 1·5 - 2 cm.

These dogs were re-opened 3 months later. The enclosed pouches were opened and were found to be distended with a mucopurulent fluid which was washed out with saline. Labelled iron and calcium were then instilled. Five millilitres of blood was taken from the superior mesenteric vein at 5-minute intervals for one hour. These isotope studies were carried out by Professor Dowdle's laboratory and showed that absorption did take place.

However, we now have to repeat these experiments making pouches without the mucosa, to show that the iso-
topes are not absorbed by the serosal surface of the small bowel. We also still have to establish the maximum area that can be safely generated.

I have presented our experimental work on generation of small bowel mucosa. The clinical application of this procedure is self-evident, provided some small bowel is present.

REFERENCES


ABSTRACTS

Primary Gastro-Intestinal Lymphoma: A Clinico-Pathological Study of 57 Cases

LEONARD B. KAHN, M.B., B.CH., M.MED.PATH., GOLDA SELZER, M.B., CH.B., F.R.C.PATH. AND RONALD O. C. KASCHULA, M.B., CH.B., M.MED.PATH., Department of Pathology, University of Cape Town and Groote Schuur Hospital

Fifty-seven cases of primary gastro-intestinal lymphoma seen over the 17-year period 1952 - 1959 have been investigated. This up-dates a previous study by Uys of 17 cases seen in the same department from 1952 to 1957. Nineteen of these arose in the stomach, 34 in the small bowel and 4 in the large bowel. Small-bowel lymphomas occurred in younger individuals than lymphomas of the stomach and the small-bowel lymphomas in adults were almost exclusively in Coloureds. Thirty-three per cent of the patients with small-bowel lymphoma presented as a malabsorption syndrome.

Lymphocytic lymphomas were by far the commonest type in both stomach and small bowel. Lymphocytic lymphomas of the stomach must be differentiated from anaplastic carcinoma and also from pseudo-lymphomas. No correlation could be found between the 5-year survival, the histological type, size of lesion or lymph node involvement.

The 5-year survival of lymphomas of the stomach was 29%. The only patients who are alive are those in whom the tumour has been completely resected and subsequent radical radiotherapy administered. The prognosis of the small bowel lymphomas was extremely poor.

The Isolated Perfused Pig Liver

R. HICKMAN, J. PARKER, S. J. SAUNDERS AND J. TERBLANCHE (with the skilled technical assistance of MRS J. COX, MR G. ENGELBRECHT AND MR A. ABBOTT), Departments of Surgery and Medicine, University of Cape Town and Groote Schuur Hospital and Provincial Blood Grouping Laboratories, Cape Town

During the course of extracorporeal hepatic assist of 4 patients with fulminant viral hepatitis, a major problem of thrombocytopenia was encountered. Laboratory studies of the isolated pig liver perfused with fresh human blood showed the same pattern of thrombocytopenia which has now been further investigated. Initial tests showed that within 10 minutes platelet loss of 70%, occurred into the liver (platelet counts being compared in the inflow to, and effluent from, the liver) and that the oxygenator played only a minor role in the platelet destruction. Total leucocyte count and complement levels also fell.

Further investigation of the human plasma showed antibody with lymphocytotoxic, leucocyte agglutinating and isoagglutinating properties which was consumed after 30 minutes' perfusion. As yet, attempts to prevent this acute response to xenogeneic perfusion have been unsuccessful, using hydrocortisone, Dipryridamole, phenylbutazone and Trasylol in clinically acceptable dosage. To date on only one occasion has the blood group of the pig corresponded with that of the human donors. On all other occasions, group-O pig livers have been perfused with group-A human blood. Further studies are in progress to determine additional properties of the antibody and to attempt to prevent the formation of antigen/antibody complexes.