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Article 1: General Surgery

Abnormal high-resolution manometry findings and outcomes after paraesophageal hernia repair. Wirsching A, Zhang Q, McCormick SE, et al. *J Am Coll Surg* 2018;227:181–188

Article 2: Pediatric Surgery

Home antibiotics at discharge for pediatric complicated appendicitis: friend or foe? Anderson KT, Bartz-Kurycki MA, Kawaguchi AL, et al. *J Am Coll Surg* 2018;227:247–254

Article 3: General Surgery

Opioid medication use in the surgical patient: an assessment of prescribing patterns and use. Tan WH, Yu J, Feaman S, et al. *J Am Coll Surg* 2018;227:203–211

Article 4: Infections; General Surgery

Statewide collaborative to reduce surgical site infections: results of the Hawaii Surgical Unit-based Safety Program. Lin DM, Carson KA, Lubomski LH, et al. *J Am Coll Surg* 2018;227:189–197

Objectives: After reading the featured articles published in this issue of the *Journal of the American College of Surgeons* (JACS), participants in this journal-based CME activity should be able to demonstrate increased understanding of the material specific to the article featured and be able to apply relevant information to clinical practice.

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ARTICLE 1

(Please consider how the content of this article may be applied to your practice.)

Abnormal high-resolution manometry findings and outcomes after paraesophageal hernia repair

Wirsching A, Zhang Q, McCormick SE, et al
J Am Coll Surg 2018;227:181–188

Learning Objectives: After study of this article, surgeons should be able to recognize that abnormal motility patterns are seen in more than 50% of patients with giant paraesophageal hernias. Although it is important to take into account major motility issues in these elderly patients when they are discovered, the majority of patients can undergo standard hiatal repair and antireflux procedures without the expectation of a higher incidence of postoperative complications, including dysphagia.

Question 1

Routine assessment before elective surgical repair of paraesophageal hernias includes all of the testing below EXCEPT:

- Esophagogastroduodenoscopy
- High-resolution manometry
- Upper gastrointestinal contrast study
- Preoperative laboratory test
- CT chest/abdomen

Critique: Patients with paraesophageal hernias are often elderly and present with a wide variety of symptoms including GERD, chest pain, dysphagia, and early

satiety. Preoperative assessment should include investigations that either confirm that these symptoms are likely due to the complex hiatal hernia or rule out other issues contributing to the symptoms. The best assessment for getting specific information regarding size and orientation of the hiatal hernia is an upper gastrointestinal contrast study. Endoscopy helps rule out other factors such as esophageal stricture, active esophagitis, Barrett's esophagus, Cameron erosions, and other gastric pathology. High-resolution manometry has historically been used to rule out major motility diagnoses; the significance of other minor disorders of peristalsis are of unknown significance. Routine preoperative laboratory testing is recommended as for other surgical procedures of similar complexity. Routine CT of the chest and abdomen is not required.

Question 2

As part of the evaluation for paraesophageal hernia (PEH), high-resolution manometry has historically been done to rule out diagnoses associated with major motility disorders. Which of the following abnormal motility findings would necessitate an operative approach different than a standard PEH operation?

- a) Esophagogastric junction outflow obstruction
- b) Ineffective esophageal motility
- c) Achalasia
- d) Presbyesophagus
- e) Fragmented peristalsis

Critique: High-resolution manometry can identify a wide variety of minor and major motility issues. Esophagogastric junction outflow obstruction and ineffective esophageal motility are commonly seen in patients with giant paraesophageal hernias. Presbyesophagus is typically associated with hypoperistalsis and is most commonly seen in the elderly population. Other preoperative diagnoses, such as jack-hammer esophagus and achalasia, can lead to the necessity of a different overall management approach.

Question 3

The most common type of paraesophageal hernia seen in virtually all high-volume reports includes:

- a) Type 1
- b) Type 2
- c) Type 3
- d) Type 4
- e) Parahiatal hernia

Critique: Orientation of the fundus and the body of the stomach and the location of the esophagogastric

junction help differentiate the various types of large hiatal hernias. The best investigation to identify size and orientation involves an upper gastrointestinal contrast study. The location of the esophagogastric junction and whether the hernia involves other viscera, most commonly colon or small bowel, helps differentiate between the 3 different types of paraesophageal hernias. Overall, the most common type of hiatal hernia is the standard sliding hiatal hernia. In this study, preoperative esophagograms showed a type-3 paraesophageal hernia in a majority of patients with abnormal and normal preoperative motility (94% vs 88%, $p = 0.16$).

Question 4

Irrespective of the identification of nonspecific or minor motility disorders, patients undergoing elective paraesophageal hernia repair can expect to see improvement in all of the listed preoperative symptoms EXCEPT:

- a) Retrosternal pain
- b) Regurgitation
- c) Dysphagia
- d) Right upper quadrant pain with meals
- e) Early satiety

Critique: Patients with paraesophageal hernias will have a wide variety of symptoms potentially related to their hiatal hernia. Previous publications have identified that preoperative symptoms can include heartburn, early satiety, retrosternal pain, dyspnea, dysphagia, regurgitation, and iron deficiency anemia. Paraesophageal hernia repair can restore normal anatomy including restoring the esophagogastric junction to the intra-abdominal position. Typically, an antireflux procedure is also done as a routine component of the hiatal hernia repair. This article highlights that minor motility disturbances do not lead to a deterioration in expected symptomatic improvement after elective repair. Right upper quadrant pain with meals may indicate symptoms related to cholelithiasis and is not often a symptom related to paraesophageal hernia.

ARTICLE 2

(Please consider how the content of this article may be applied to your practice.)

Home antibiotics at discharge for pediatric complicated appendicitis: friend or foe?

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