unnecessary surgery"

several points made by Drs. McCarthy and Finkel state, “All elective, nonemergency operations are included in the study.” This in itself is one of the major shortcomings. As we previously noted, “... little distinction is made between elective operations and discretionary procedures. The latter frequently incorporate the desires of the patient into the decision-making process.” The directors of the Cornell study do not feel that this differentiation is significant. However, those procedures which involve incorporation of the patient’s wishes into the surgical decision making process consistently demonstrate the highest nonconfirmation rates. These include hysterectomy (27.3%), vein stripping and ligation (23.4%), and knee surgery (20.8%). A need for classification of surgical opinions into those which did and did not incorporate patients’ desires might be indicated if data from such programs are to be interpreted meaningfully.

Lastly, we stand by our statement, “... there are well known regional differences in short-stay hospital admissions, with the northeast United States having the highest percentage of patients hospitalized for surgical procedures.” It is crucial that such health statistics be factored into the overall assessment of second-opinion programs when evaluating their cost-effectiveness from one section of the country to the next.

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Operative implications of preduodenal portal vein
To the Editors:

Makey and Bowen, in their recent article, “Preduodenal portal vein: Its surgical significance,” warn of the...
surgical risks of a preduodenal vein in operations about the portal triad. We would like to point out the wider surgical implications of this anomaly, that is, the rarity of preduodenal vein as an isolated malformation. The portal venous anomaly is often just one manifestation of a constellation of perihepatic vascular and intestinal malformations. Of major interest to the surgeon are the associated vascular anomalies of aberrant hepatic artery and absent inferior vena cava. In the former, the right hepatic artery originates from the superior mesenteric artery and runs posteriorly in the portal triad. Because of the unusual location, it may be subject to operative injury. An absent inferior vena cava results from a failure of union of the hepatic and subcardial veins. Venous blood from the lower body returns to the heart via the azygous and/or hemiazygous systems.

The technical problems posed by this triad of perihepatic vascular anomalies were described by us earlier in operations upon patients with biliary atresia. In such patients, the vascular malformations may be anticipated by characteristic findings on plain chest films (Fig. 1). At first it was thought that the composite vascular anomaly precluded orthotopic liver transplantation. Since those publications, however, a child with these malformations had a successful transplantation and has survived with her homograft for more than 4 years.

The composite vascular anomaly also assumes significance in operations not directly involving the liver. An absent inferior vena cava would present a major surgical obstacle in portacaval shunt operations or in vena caval ligation. Moreover, in one of our patients, division of the azygous vein during tracheoesophageal fistula repair effectively interrupted the total venous drainage of the lower half of the body and contributed to the infant's death. Discovery of a preduodenal vein at operation should immediately alert the surgeon to the real possibility of other major vascular malformations in the surgical area.

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References

More on preduodenal portal veins
To the Editors:

After reviewing the recent article by Makey and Bowen, "Preduodenal portal vein: Its surgical significance," we wish to commend them on pointing out the need for awareness of this anomaly in biliary tract surgery. As the authors explained, this is a rare anatomical variant, which usually is associated with other congenital anomalies. Therefore, it is more likely to be encountered in surgery on the pediatric age group. Wakayama reported a case of preduodenal portal vein associated with congenital biliary atresia, intrahepatic interruption of the inferior vena cava with asygos continuation, incomplete annulus pancreas, and accessory spleens in February, 1976. At that time he reported 55 cases of preduodenal portal vein in the

Reference

Reply
To the Editors:

Dr. Makey and Bowen's article on preduodenal portal veins in biliary atresia was well received. We agree with the authors that this anomaly is rare and should be considered in the differential diagnosis of biliary atresia. The report by Wakayama was also valuable in highlighting the complexity of these cases. Further research is needed to better understand the clinical significance and surgical implications of preduodenal portal veins in biliary atresia.