

2. Malik MA, Tahir MA, Sawyna V: Treatment of symptomatic reflux esophagus with Angelchik prosthesis and its complications. Exhibit presented to the Clinical Congress, American College of Surgeons, Chicago, Oct. 24-29, 1982.

Reply

To the Editors:

I am pleased that Drs. Malik, Tahir, and Sawyna in their practice have experienced a reduction in the incidence of complications with the Angelchik device. I would, however, disagree with their contention that the mortality and morbidity rates of fundoplication are higher than those with the Angelchik collar.

The problems I alluded to in my editorial,¹ which seem to be specific to the Angelchik prosthesis, are migration of an intact device into the mediastinum or pelvis, usually because the ribbons untie or split entirely from the prosthesis, disruption of the prosthesis envelope permitting the contents of the device to be extruded into the chest or abdomen, and erosion of the device into the lumen of the bowel.

The manufacturer recently has modified the ribbons so that they now encircle the entire prosthesis. I share the hope of Dr. Malik and his colleagues that this modification will help to keep the ribbons and the rest of the device together. Only time and rigorous follow-up of every implanted device by the manufacturer will provide us with an answer. The problems of the ribbons becoming untied, the prosthesis envelope disrupting, and the device eroding into bowel are unlikely to be affected by this modification.

There is a further problem with the Angelchik device that deserves attention—dysphagia after implantation. While dysphagia resolves in some patients, it persists for more than 3 months in up to 10% of patients and is severe enough in some cases to require removal of the prosthesis.

All of these problems with the Angelchik device would be acceptable if there were no alternative for successful surgical control of reflux esophagitis. But there is a ready alternative. The fact is that a fundoplication is a better operation for symptomatic reflux than insertion of the Angelchik device. In my personal series of more than 200 primary elective fundoplications that have been done for reflux esophagitis, there have been no deaths and only one case of persisting dysphagia. The incidence of complications that prolong the postoperative hospital stay beyond 10 days is less than 2%. The incidence of both early and late recurrent or persisting reflux is less than 5%.

It is my opinion that too many surgeons who insert Angelchik prostheses do so because they are insufficiently skilled to accomplish a successful fundoplication in difficult cases. In my view, such surgeons should refer their patients to a more skilled surgeon rather than subject them to the hazards of an unnecessary prosthesis.

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Reference

1. Condon RE: More misadventures with the esophageal collar. *SURGERY* 93:477-8, 1983

When can revascularization be limited to the isolated popliteal artery?

To the Editors:

In their recent letter J. Watelet et al.¹ introduced a point that we feel requires some comment in view of the fact that 15 of their 30 bypasses to an isolated popliteal artery were with in situ veins.

In a series of 407 in situ vein bypasses, we have had occasion to bypass to an isolated popliteal artery on only 26 occasions (6%). We now believe that with refinements in the technique of the in situ bypass, the need to bypass to an isolated popliteal artery should become less frequent and should be limited to the following circumstances: first, when there is no vein available for use as an in situ bypass or when there is insufficient length of an in situ vein to reach distally past an isolated popliteal artery; and second, when there is no suitable distal artery for bypass other than an isolated popliteal artery. Our results with 242 infrapopliteal bypasses would indicate that this is an infrequent occurrence. Eighty-six of the 242 infrapopliteal bypasses were to the peroneal artery, and the cumulative patency rates were 93% at 1 month and 80% at 2 years.

In view of our experience, in cases in which an in situ vein bypass is contemplated and there is a choice between an isolated popliteal artery and a tibial artery, we believe that the tibial artery should be used for limb revascularization.

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Reference

1. Watelet J, Philippe JM, Chamoun S, Testar J: When can revascularization be limited to the isolated popliteal artery? *SURGERY* 93:725, 1983

Nutritional support of the hospitalized patient

To the Editors:

I read Dr. Skillman's⁶ recent editorial "Should Intravenous Protein and Fat be Administered?" with much interest as numerous critical points were raised.

In performing important metabolic research related to differing sources of energy to support surgical patients, Dr. Skillman rightfully notes the shortcomings in relying upon changes in albumin, nitrogen balance, and body weight to decide the efficacy of therapy. With the days of diagnostic-related group reimbursement upon us, he is quite properly concerned about the extra cost that intravenous amino acids,