Chapter 85: Selective Vagotomy, Antrectomy, and Gastroduodenostomy for the Treatment of Duodenal Ulcer e-1
Lloyd M. Nyhus

Selective vagotomy, antrectomy and gastroduodenostomy for the treatment of duodenal ulcer is an operation that is no longer done. Very frequently partial cell vagotomy has largely supplanted selective vagotomy, but antrectomy and gastroduodenostomy are useful for carcinoma of the stomach with some slight modifications as pictured elsewhere in the book. This is a classic chapter, and it is included for historical reasons but also because Dr. Nyhus, one of the originators of Masters of Surgery wrote a superb chapter. It can be read with profit.

Chapter 86: Selective Vagotomy and Pyloroplasty e-13
Steven D. Schwatzberg, John L. Sawyers, and William O. Richards

Dr. Steven Schwatzberg has written an excellent chapter on selective vagotomy and pyloroplasty. However, as Dr. Schwartzberg pointed out to me himself, this is an operation that is no longer done very frequently, if at all. However, it is a chapter that elucidates some points concerning surgery of the stomach, unfortunately no longer carried out with any great degree of regularity. It is a chapter that can be read with significant profit.

Chapter 139: Distal Splenorenal Shunts: Hemodynamics of Total versus Selective Shunting e-21
Atef A. Salam

The distal splenorenal shunt was advocated originally as an operation for portal hypertension which had a lower rate of hepatic encephalopathy as compared to the central splenorenal shunt (which is useful in patients with significant ascites, patients on whom distal splenorenal is contraindicated), a claim which has not held up. In addition, recent data from randomized prospective trials seem to conclude that the portacaval shunt is at least as good and perhaps better as in regard to long term outcomes. (See commentaries on Chapters 137 and 138)

Chapter 145: The Continent Ileostomy e-30
Eric J. Dozois and Roger B. Dozois

This procedure was originally proposed as an alternative to Ileal Pouch Anal Anastomosis. However, as the pouch has become the standard operation for ulcerative colitis—and in some hands, familial polyposis—very few now perform this procedure.

Chapter 152: Care of Stomas e-37
Laurie Maidl and Jill Ohland

The care of stomas has become a nursing subspecialty, and the presence of a stoma nurse is a very important part of most hospitals of any size. The stoma nurse helps with preoperative planning of the operation, siting of the ileostomy or colostomy, help with difficult stomas, and care of patients with gastrointestinal cutaneous fistulas.

Chapter 180: Operations on the Ureteropelvic Junction e-53
Frank Hinman, Jr.

“Operations of the Ureteropelvic Junction” is another operation that has given way to minimally invasive and endourological procedures. Dealing with the ureteropelvic junction in open fashion is an art form that will be applied to the minority of patients. Nonetheless, it is important that one know how to do the operation if the occasion demands and the preservation of renal function is at stake.

Chapter 194: Anterior and Posterior Colporrhaphy e-60
Dionysios K. Veronikis

The chapter on anterior and posterior colporrhaphy presented here is a rather detailed chapter and one which can be read with profit. However, the vaginal floor and its repair has become much more complicated and so anterior and posterior colporrhaphy, in and of itself, are used less frequently. They may be used with operations for the prolapse of the rectum and they may be utilized in the more sophisticated approach to cystocele and urethracele.

However, the anatomy which is described in the anatomical repair, is valuable and can shed light in other specialties to the necessity for having pelvic floor repair, for example, or come in useful as stated in my commentary for repair of rectal prolapse.

Chapter 196: Bassini Operation e-75
Oreste Terranova, Luigi De Santis, and Flavio Frigo

Drs. Terranova, DeSantis and Frigo, as they have in the past, have contributed to the classic operation which started all repairs of inguinal hernia by Dr. Edoardo Bassini. “The Bassini Operation” probably is the first that gained credence and has held for approximately 100 years or more. However, as the authors come to the conclusion that “The Bassini Operation” even carried out with repair of the transversalis fascia, as originally described by Bassini and shown here in the original pictures, has a recurrence rate anywhere from 3–22% although it may fall as they say in the text below 1.5–2%. They come to the conclusion that while of historical interest and of interest as far as the anatomy of the inguinal canal, this operation as currently described in and of itself is no longer viable. The Shouldice operation described elsewhere in this volume may actually disagree with that particular conclusion. But according to the authors, prosthetic material must be used in order to get a reasonable recurrence rate. Thus, despite the importance of Bassini and his operation as it was originally described, this is no
longer a contemporary utilization of surgery for inguinal hernia cause of the recurrence.

It is presented on the website for historical interest as it really started everything. One may differ as to whether or not Shouldice repair is useful or whether I use a variant of the Shouldice operation, sometimes with vicryl mesh and seem to have low recurrence rates. However, the reader will decide from all of the repairs which are made available in the hernia section.

Chapter 197: Cooper Ligament Repair of Groin Hernias e-87
Robb H. Rutledge

Dr. Robb Rutledge is an excellent practitioner who preceded me in the Massachusetts General Hospital residency by a number of years. He is an exemplary gentleman and a superb surgeon who, despite being in private practice is highly academic in his approach. I consider him a friend. The Cooper’s ligament repair once was a staple of herniorraphy. Indeed, when I was a resident, the Cooper’s ligament repair was the standard procedure we carried out at the Massachusetts General Hospital despite the fact that it is more painful and its primary utility is in the area of femoral hernias. Dr. Rutledge nicely describes it. The chapter appeared in the fourth edition.

Chapter 198: The Shouldice Method of Inguinal Herniorrhaphy e-96
Robert Bendavid

The Shouldice Clinic declined to bring the operation up to date. It is still useful to review this procedure because it is, in its best sense, the descendent of the Bassini repair. It has largely been supplanted by the various mesh repairs and the Lichtenstein tension free repairs.

Chapter 199: Iliopubic Tract Repair of Inguinal Hernia: The Anterior (Inguinal Canal) Approach e-108
Robert E. Condon

Lloyd M. Nyhus

Chapters 172 and 173 are two classic articles appearing from a golden age in surgery, the collaboration with Dr. Robert Condon and Dr. Lloyd Nyhus. They deal with the anatomy first and foremost of the inguinal canal by two individuals who have made this a major focus of their long and distinguished academic careers. The anatomy is masterfully described and is well argued. Familiarity with this approach is essential because there are times when there is a hernia in the vicinity of the abdomen and anatomical knowledge of this area will enable a repair to be done with less difficulty, thus preventing another operative procedure.

These two classics have appeared in every previous edition and they are included here on the website. At a time when most surgical residents never learn the anatomy of the inguinal canal, which I find unfortunate, these two chapters are superb in how the knowledge of surgical anatomy can lead not only to a concept but also to performance of an excellent clinical operation at that time.

Chapter 204: Giant Prosthesis for Reinforcement of the Visceral Sac in the Repair of Groin and Incisional Hernias e-126
René E. Stoppa

The Stoppa procedure is good for bilateral hernia and has the advantage of a very low complication rate of inguinodynia, which occurs in as many as 10% of groin prosthetic repairs. Patients with severe inguinodynia are incapacitated and operative repair is successfully only in up to 80% of patients.
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