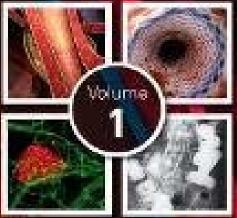




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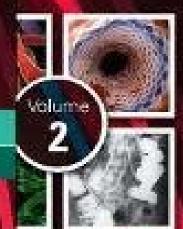
SURGERY of the ALIMENTARY TRACT





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2-Volume Set

Shackelford's SURGERY of the ALIMENTARY TRACT





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SHACKELFORD'S SURGERY OF THE ALIMENTARY TRACT, EIGHTH EDITION

ISBN: 978-0-323-40232-3 Volume 1 part number: 9996118169 Volume 2 part number: 9996118223

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Library of Congress Cataloging-in-Publication Data

Names: Yeo, Charles J., editor.

Title: Shackelford's surgery of the alimentary tract / [edited by] Charles J. Yeo.

Other titles: Surgery of the alimentary tract

Description: Eighth edition. | Philadelphia, PA: Elsevier, [2019] | Includes bibliographical references and index.

Identifiers: LCCN 2017042680 | ISBN 9780323402323 (hardcover : alk. paper)

Subjects: | MESH: Digestive System Surgical Procedures-methods | Digestive System Diseases-surgery

Classification: LCC RD540 | NLM WI 900 | DDC 617.4/3-dc23 LC record available at

https://lccn.loc.gov/2017042680

Executive Content Strategist: Russell Gabbedy Content Development Specialist: Mary Hegeler Publishing Services Manager: Patricia Tannian Senior Project Manager: Amanda Mincher Design Direction: Patrick Ferguson

Printed in China

to grow libraries in developing countries

www.elsevier.com • www.bookaid.org

Working together

To my wife, Theresa, and my children, William and Scott; to my many mentors (some now deceased, many still alive) who have contributed to the science of surgery and to my education; to the many colleagues and friends whose contributions have made this eighth edition possible; and to those young alimentary tract surgeons and other health care professionals who will learn from these pages, move the field forward, and continue to improve our understanding of alimentary tract diseases.

CHARLES J. YEO

To my father, Tom DeMeester, whose passion for understanding the pathophysiology of esophageal and foregut disorders and applying this knowledge to better the lives of patients has been and remains an inspiration for me; to my many mentors who have helped me learn the craft of surgery and encouraged me to constantly strive for perfection; to my colleagues who give up many hours of their evenings, weekends, and vacations to contribute to abstracts, papers, and book chapters; to my fellows and residents who diligently train to be the next generation of expert surgeons; and to my family and friends who support me and graciously accept my long hours away at work caring for people in need of help.

STEVEN R. DEMEESTER

I would like to dedicate this book to all the past residents and fellows with whom I have worked and to thank them for making education such a wonderful part of my life; I hope this will help us to remember the times we've spent together taking care of complex patients and will encourage you to continue to pass on your knowledge to those whom you mentor.

JAMES W. FLESHMAN

To Dr. William Silen and my late grandfather, Dr. Benjamin M. Banks, for their wisdom; to the surgical residents and students, for their thirst for knowledge; and to my wife, Joan, and our boys, Jonathan, David, and Adam, for their love and support.

JEFFREY B. MATTHEWS

To my wife, Nancy, and my children, William, Hunter, and Nora; and to all of my mentors, colleagues, and patients who challenge and inspire me every day.

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Shackelford's Surgery of the Alimentary Tract, Eighth Edition

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Preface

The time has come to release the eighth edition of the classic textbook *Shackelford's Surgery of the Alimentary Tract.* This publication has served as an important resource for surgeons, internists, gastroenterologists, residents, medical students, and other medical professionals over the past 61 years. I hope that you will find the eighth edition brimming with new information, beautifully illustrated, up to date, and educationally fulfilling.

BRIEF HISTORY

The first edition of *Surgery of the Alimentary Tract* was written solely by Dr. Richard T. Shackelford, a Baltimore surgeon, and was published in 1955. Following the success of the first edition, the book's publisher, W.B. Saunders Company, urged Dr. Shackelford to produce a second edition. Considerable time passed. A second edition was released, as separate five-volume tomes, between 1978 and 1986, with Dr. Shackelford enlisting the assistance of Dr. George D. Zuidema, the Chairman of the Department of Surgery at Johns Hopkins, as co-editor. It was the second edition that served as my "bible" for alimentary tract diseases during my surgical residency and early faculty appointment.

The third edition, edited by Dr. Zuidema, was published as a five-volume set in 1991 and proved to be a major tour de force. The field of alimentary tract surgery had advanced, new research findings were included in the edition, and emerging techniques were illustrated. For the third edition, Dr. Zuidema enlisted the help of a guest editor for each of the five volumes.

The fourth edition, again headed by Dr. Zuidema, was published in 1996 and remained encyclopedic in scope, breadth, and depth of coverage. The textbook had become a classic reference source for surgeons, internists, gastroenterologists, and other health care professionals involved in the care of patients with alimentary tract diseases.

The fifth edition was published in 2002. At that time, Dr. Zuidema asked me to join him as a co-editor. The fifth edition remained a five-volume set, and it was filled with new operative techniques, advances in molecular biology, and noninvasive therapies. It marked progress in the co-management of patients by open surgical, laparoscopic surgical, and endoscopic techniques.

In 2007, the sixth edition of *Shackelford's Surgery of the Alimentary Tract* was published. The look of the sixth edition was changed. The book went from five volumes to two volumes with the deletion of outdated material, and it included a four-color production scheme, emphasized new procedures, and focused on advances in technology. In 2012, the seventh edition was published.

THE EIGHTH EDITION

The eighth edition maintains the exterior changes and look of the sixth and seventh editions. However, the

eighth edition has been carefully planned by me and the four expert section editors to represent the current state of alimentary tract surgery as practiced throughout the world. This edition has been completed with an enormous amount of assistance from my four colleagues, who have served as editors for the four major sections of the book. These section editors have worked tirelessly, planning, organizing, and developing this massive textbook. They have incorporated numerous changes in surgical practice, operative techniques, and noninvasive therapies within the text. Although each area does retain sections on anatomy and physiology, the numerous advances in genomics, proteomics, laparoscopic techniques, and robotics are included. The eighth edition includes the contributions of two new and two retained section editors from the seventh edition, providing both innovation and stability.

Section I, Esophagus and Hernia, is now edited by Dr. Steven R. DeMeester, a Professor of Surgery at the University of Southern California, in Los Angeles. Dr. DeMeester is a nationally and internationally known expert who brings his detailed knowledge of the esophagus and esophageal diseases to the textbook. Dr. DeMeester is the son of Dr. Tom DeMeester, a legendary individual who has made numerous contributions to the field. Steve has enlisted new authors for his chapters and has put together a spectacular section on esophageal diseases, including pathology and ambulatory diagnostics, extensive sections on gastroesophageal reflux disease, esophageal motility disorders, and esophageal neoplasia.

Dr. David W. McFadden remains as the editor for Section II, Stomach and Small Intestine. Dr. McFadden works at the University of Connecticut in Farmington, Connecticut, serving as the Professor and Chairman of the Department of Surgery and the Surgeon in Chief of their health system. Dr. McFadden is an expert in alimentary tract diseases, surgical research, and education. He served for many years as the co-editor-in-chief of the *Journal of Surgical Research*, and he has served as the president of the Society for Surgery of the Alimentary Tract. He has done a superb job of enlisting many new chapter authors so as to present an updated section regarding the luminal structures of the upper gastrointestinal system. Dr. McFadden's section is an outstanding contribution to this area.

For Section III, Pancreas, Biliary Tract, Liver, and Spleen, we have retained our section editor, Dr. Jeffrey B. Matthews, the Dallas B. Phemister Professor and Chairman of the Department of Surgery at the University of Chicago, in Chicago, Illinois. Dr. Matthews' surgical career has focused on diseases of the nonluminal structures of the alimentary tract, and he has done a superb job in enlisting new contributors and reorganizing this section. Dr. Matthews' credentials include serving as the editor-in-chief of the *Journal of Gastrointestinal Surgery*, and he is also a recent past president of the Society for Surgery of the Alimentary Tract. This section serves as an outstanding contribution to the field.

Finally, Section IV, Colon, Rectum, and Anus, has been designed and reorganized by Dr. James W. Fleshman, the Seeger Professor and Chairman of the Department of Surgery at Baylor University Medical Center. Dr. Fleshman is an internationally known figure in his field, and his section has been totally reorganized. Included are various new developments in the field, updates on pelvic floor anatomy and physiology, new therapies for inflammatory bowel disease, increased emphasis on laparoscopic interventions, and new chapters dealing with the topics not previously presented.

ACKNOWLEDGMENTS

The eighth edition would have been impossible to complete without the expertise, dedication, and hard work of each of these four expert section editors. They have been helped immensely by their colleagues, staff, and all the chapter contributors. I would like to thank each of these section editors for their vision, dedication, expertise, and incredible hard work in bringing this project to fruition.

As is often the case with printed works of this size, hundreds of individuals have contributed chapters to this edition. In fact, hundreds of contributors are listed in the contributors section. We understand how difficult it is to produce superb chapters, and I wish to recognize these individuals and thank them for their dedication and commitment. Most of these contributors are nationally and internationally known leaders in their fields. I am deeply indebted to them for sharing their knowledge and enthusiasm about their topic, culminating in an outstanding overall product.

I would also like to thank the publishing team at Elsevier, who again have been instrumental in making this edition a reality. My thanks go out to Michael Houston, Mary Hegeler, Amanda Mincher, and many others who have been involved in overseeing this project. This edition represents an enormous amount of new work, and thousands of hours have been spent on its production. These professionals have made it a labor of love to work on this project.

Finally, I must thank individuals who have helped me during this new edition process over the past three years. Here in my office at Thomas Jefferson University, accolades go out to Claire Reinke, Dominique Vicchairelli, and Laura Mateer who have been outstanding assistants in bringing this work to fruition.

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PART **ONE**

Anatomy and Physiology of the Esophagus

CHAPTER

1

Esophageal Sphincters in Health and Disease

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The esophagus is a muscular tube connecting the mouth with the stomach. The main function of the esophagus is transport of fluids and food to ensure regular nutrition of the body. At the proximal and distal end of the tube, special boundaries are necessary to fulfill complex functional tasks such as swallowing, belching, and vomiting and allowing breathing and coughing, while preventing substantial reflux of gastric contents into the esophagus. The proximal part of the esophagus and its upper esophageal sphincter (UES) comprise mainly striated musculature. In the esophageal corpus, a few centimeters below the UES, the structure switches through a zone of mixed striated-smooth muscle to the distal esophagus including the lower esophageal sphincter (LES) with complete smooth muscle structures. The complex function of the two sphincters is regulated and influenced by nerval innervations, pressure systems, hormonal and chemical influences, and external and possible psychological factors.

UPPER ESOPHAGEAL SPHINCTER IN HEALTH

SWALLOWING PROCESS

The UES is involved in the swallowing process. This process is complex and requires a number of important features to temporarily change the pathway of breathing air between the mouth, nose, pharynx, and the trachea into the channel for passing liquid and food farther into the esophagus.

The main anatomic structures of the upper boundary of the esophagus are the cricopharyngeal muscle connected to the cricoid cartilage. Because there is no circular symmetric muscle structure, but instead a ventral cartilage with lateral and dorsal muscular parts, the resulting pressure profile of the UES is not symmetric. It is important to note that the anatomic relations functionally change during swallowing. The UES moves upward approximately 1 cm because of the laryngeal upward swing. The innervation of the UES is mainly achieved by the vagus nerve and, to a lesser extent, by cranial nerves IX and XII.¹

Swallowing is a complex process and the UES is involved in the pharyngeal phase, which occurs later in the swallowing process. Depending on the respective author, swallowing can be described in three to six different phases.²⁶ Three main phases are often differentiated: the oral, pharyngeal, and esophageal phase.

In the oral phase, the tongue and the surrounding structures of the pharynx, the soft and hard palate, and the closed glossopalatal area form a bolus (Fig. 1.1). This process is started by will of the individual. The first step of bolus formation is performed by the soft palate and the posterior aspect of the tongue. The second component of the oral phase is the upward movement of the soft palate toward the hard palate, closing the nasopharynx, and the upward swing of the hyoid bone more ventrally.

When the tongue creates more pressure on the bolus toward the soft and hard palates, the bolus is propelled through the glossopalatal opening and enters the pharyngeal area, thus representing the transition to the pharyngeal phase (Fig. 1.2). The sequences of the pharyngeal phase happen involuntarily. In health, the most important part of the process is the well-coordinated closure of the airway during the passage of the bolus. The nasopharyngeal area is closed by the soft palate and the posterior pharyngeal wall. The muscles of the floor of the mouth pull the hyoid bone, and subsequently the larynx and cricoid, anteriorly and upward, thus allowing the epiglottis to flip downward and close off the airways.

The constrictor pharyngeal muscle contracts, and the UES is opened by approximately 1 second of relaxation. The bolus leaves the pharyngeal area, moves through the hypopharynx, and into the esophagus. The esophageal phase begins as the bolus enters the proximal esophagus through the opened cricopharyngeal sphincter (Fig. 1.3). The peristaltic contractions take over propulsion of the bolus and assist gravity in transporting the bolus through the esophageal corpus. Finally, all structures return to their resting positions, and the airway is opened again as the UES closes.

ASSESSMENT OF THE UPPER ESOPHAGEAL SPHINCTER

The UES comprises cricoid cartilage at the ventral border and cricopharyngeal muscle toward its lateral and posterior borders. This structure creates the asymmetric pressure

ABSTRACT

Introduction: The esophagus is a muscular tube connecting the mouth with the stomach. The main function of the esophagus is the transport of fluids and food to ensure regular nutrition of the body. At the proximal and distal end of the tube, special boundaries are necessary to fulfill complex functional tasks such as swallowing, belching, and vomiting and allowing breathing and coughing, while preventing substantial reflux of gastric contents into the esophagus.

Structures and Function in Health and Disease: This chapter focuses on the upper esophageal sphincter (UES) and the lower esophageal sphincter (LES). The complex functions of the two sphincters are regulated and influenced by nerval innervations, pressure systems, hormonal and chemical influences, and external and possible psychological factors. The functional assessment is usually performed by radiographic studies and manometric techniques. There are many disorders that can cause cervical or oropharyngeal dysphagia. This includes myogenic, neurogenic, iatrogenic, mechanical, and psychogenic causes, as well as idiopathic dysfunctions of the UES.

The LES structure is incorporated in the distal esophagus. The major function is the proximal closure of the gastric reservoir to prevent reflux of substantial amounts of gastric contents back into the esophagus. This is important because gastric juice can be toxic for the esophageal mucosa. The major functional finding at the distal esophagus is a high-pressure zone. The most frequent failure of the LES is a weakening causing increased gastroesophageal reflux.

KEYWORDS

Esophagus, upper esophageal sphincter, lower esophageal sphincter, dysphagia, myotomy, achalasia, gastroesophageal reflux disease.

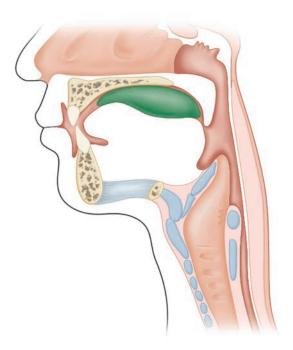


FIGURE 1.1 The swallowing process: The tongue has formed a bolus between the ventral part of the tongue and its posterior part against the soft palate.

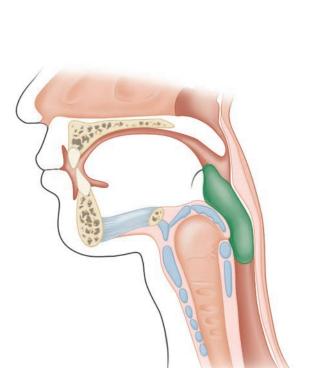


FIGURE 1.2 The swallowing process: The soft palate is lifted upward toward the hard palate, thus closing off the nasopharynx. The tongue pushes the bolus backward into the pharynx. The hyoid bone and the larynx are pulled upward, thus causing the epiglottis to flip down and close off the trachea. The upper esophageal sphincter relaxes to prepare the passage of the bolus.

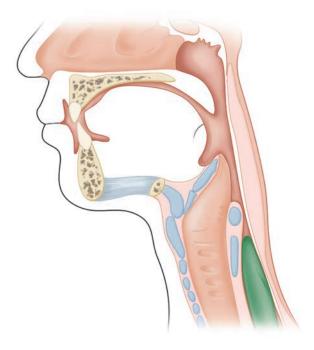


FIGURE 1.3 The swallowing process: The upper esophageal sphincter is fully relaxed for a short time in which the bolus passes into the proximal esophagus, where it is pushed farther by gravity and esophageal peristalsis. The larynx and epiglottis then resume their resting positions.

profile of the sphincter. Functional assessment of the UES is usually performed by radiographic studies or manometric techniques. ^{2.5} Routine radiographic investigations by barium swallow provide insight into the swallowing process and demonstrate pathologic anatomic alterations such as a Zenker diverticulum. However, a subtle functional failure of the regular swallowing process—for example, as a result of a discrete neurologic defect causing cervical dysphagia—might be missed. High-speed photography using a specialized kinematographic analysis may be necessary to describe dysfunctions in detail. ⁴ Video documentation allows for repetitive visualization and analysis of the findings.

Clinical assessment of symptoms is necessary to clearly determine the underlying functional problem and the impact of the disorder on the patient's quality of life. Endoscopy is important in detecting or excluding malignant disease and obstruction.

Pharyngoesophageal manometric studies can demonstrate the physiologic swallowing function through the UES and possibly its pathologic changes. ^{5,7-10} The UES is asymmetric and changes its pressure profile in milliseconds during swallowing. Consequently, traditional perfusion manometry with a few recorded openings and manometry probes with only a few solid-state pressure transducers cannot demonstrate subtle pressure increases or relaxations or coordination features along the vertical axis. Manometry systems with multiple recording sites along the probe and circumferentially on the probe are necessary to record sufficient data to fully describe the complex process of