extension to the left supraclavicular area is made, and the aortic arch and its three major branches are dissected. Cardiopulmonary bypass is instituted with an inflow cannula in the femoral artery, and vena caval catheters inserted through the right atrium. A heat exchanger in the bypass circuit lowers the patient's temperature to 20°C. The circulation is stopped, and the patient's temperature drifts down to 12 to 15°C. The aortic arch vessels and the descending thoracic aorta are clamped, and the aortic arch is opened. An ellipse of aorta containing the orifices of three arch vessels is tailored and prepared for anastomosis. A dacron graft is anastomosed end-to-end to the descending thoracic aorta. A slit is cut in the superior aspect of the graft, and the ellipse of the aorta containing the arch vessels is sewn into the graft. A cross-clamp is placed around the graft proximal to the arch vessels, the other vascular clamps are removed and cardiopulmonary bypass is reinstituted. Using surface warming and a heat exchanger, the patient's temperature is brought to normal during anastomosis of the graft to the ascending aorta or, if the ascending aorta requires replacement, to the aortic annulus.

With an average-sized adult the period of core cooling is approximately 30 minutes, the period of circulatory arrest is 30 to 40 minutes and the period required for warming is one to one and a half hours. Patients awaken promptly, and in most cases ventilatory support is discontinued and ambulation is begun on the first postoperative day.

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Intestinal Bypass in the Treatment of Obesity

SHORTENING THE FUNCTIONAL intestinal tract by jejunocolostomy to cure intractable obesity fell into disrepute when the operation resulted in serious, sometimes fatal deficiency syndromes. During the past ten years the end-to-side jejunoileostomy introduced by Payne in Los Angeles has achieved increasingly wide acceptance as a safe and effective surgical cure of morbid obesity.

More recently, Scott's end-to-end jejunoileostomy and Printen's gastric bypass have been introduced in an attempt to improve the results, but it is too soon to evaluate comparable long-term follow-up.

There are now hundreds of patients in many cities who have been given a new lease on life by the only treatment for massive obesity so far devised with a minimal recurrence rate.

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Pancreatic Trauma: Management and Presentation of a New Technique

INJURIES TO THE RETROPERITONEAL ORGANS, including the pancreas, are increasing in association with the high incidence of abdominal trauma caused by highway accidents. Because of its relatively protected retroperitoneal position, the injuries to the pancreas account for only 1 to 2 percent of all traumatic abdominal injuries. The types of treatment used for pancreatic injury are as varied as the location and extent of damage to this organ.

Damage to the pancreatic head requires special consideration. There are two alternatives when treating injuries in this area. One is external drainage with or without suture repair and the other is pancreaticoduodenectomy. Contusions of the pancreatic head, small parenchymal lacerations and occasionally low velocity, through-and-through gunshot wounds may be managed by external drainage alone. Pancreaticoduodenectomy is done when there is extensive devitalization of the pancreatic head, complete proximal ductal disruption, uncontrollable bleeding from the injured area or extensive devitalization of the duodenum. The rate of mortality following pancreaticoduodenectomy and reestablishment of gastrointestinal continuity is high because of inability of the patients to sustain the traumatic injury and the superimposed surgical trauma. In selected cases it may be preferable to resect the stomach, duodenum and pancreas, and exteriorize the en-