P-073A A Case of Covered Cloacal Exstrophy
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Aim: To report the surgical treatment of a case
of covered cloacal exstrophy.
Case report: A 5-year-old girl with covered cloa-
cal exstrophy (CCE) was referred to us for
further management. An ileostomy had been
performed elsewhere. She had a long, wide cloa-
cal channel (CC) connected to an extremely
broad bladder neck with no urinary sphincter,
rendering her totally incontinent. The cecum, 2
uteri, and 2 ureters also opened into the blad-
der. The cecum had 2 appendices. The colon
was short, blind-ended and hugely dilated. Both
kidneys and both ovaries were normal. At
surgery, the CC and bladder were used as a
vagina, both ureters were ligated and divided
distally, and the cecum was excised from the
bladder to create a continent urinary reservoir
(CUR) with the blind-ended colon. The left
ureter was reimplanted into the CUR. The right
ureter was exteriorized as an ureterostomy, and
both appendices were exteriorized for urinary
catheterization (UC). The ileum transected from
the cecum was pulled-through using a modified
Georgeson’s procedure to create a neoanus.
The postoperative course was uneventful and UC
started. Eleven months later, the right ureter
was reimplanted into the CUR. At follow-up 2
months later, she was dry with urinary catheter-
ization and continent, with no urinary tract infec-
tions.
Conclusion: The anatomy of CCE is complex
and often unique, and treatment should be indi-
vidualized. CUR created from a short colon
appears to be useful for treating urinary inconti-
nence in a subgroup of CCE cases, greatly
improving their quality of life.

P-074A Anterior Transposition of the Third
Part of the Duodenum for the Treatment of
Superior Mesenteric Artery Syndrome
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We report a case of superior mesenteric artery
syndrome (SMAS) treated by anterior trans-
position of the duodenum (ATD) and conduct
a literature review. A 14-year-old female with
SMAS was referred following failure of conserv-
ative management. At laparotomy, the pancreas
(P), the duodenum (D) and the superior mesen-
teric vessels (SMVs) were exposed. The fourth
part of D was mobilized and the Treitz liga-
ment divided. Branches of the first jejunal
artery and vein and branches of the inferior
pancreaticoduodenal arteries and veins were
carefully selected and divided to maintain blood
supply to the part of D to be transected later.
The third part of D was mobilized from the tail
and body of P, dissected to about 1cm from the
uncinate process of P then transected about 2
cm to the left of the SMVs. SMVs were dis-
placed posteriorly between the cut ends of D.
An end-to-end duodenoduodenostomy anterior
to the SMVs was performed. Plication of the
proximal D was performed and the abdomen
closed. Postoperative course was uneventful.
Postoperative barium meal demonstrated
smooth passage through a normal caliber D.
Oral intake was commenced on postoperative
day 5 and she was discharged on postoperative
day 11. After 13 months she is eating well with-
out any recurrence. In the literature, there are
only 22 ATD patients-all are well; there are no
reports from pediatric surgeons about SMAS
treated by ATD; outcome of bypass surgery
widely performed for SMAS is unacceptably
poor. ATD appears to be safe for permanently
circumventing the duodenal obstruction seen in
SMAS.