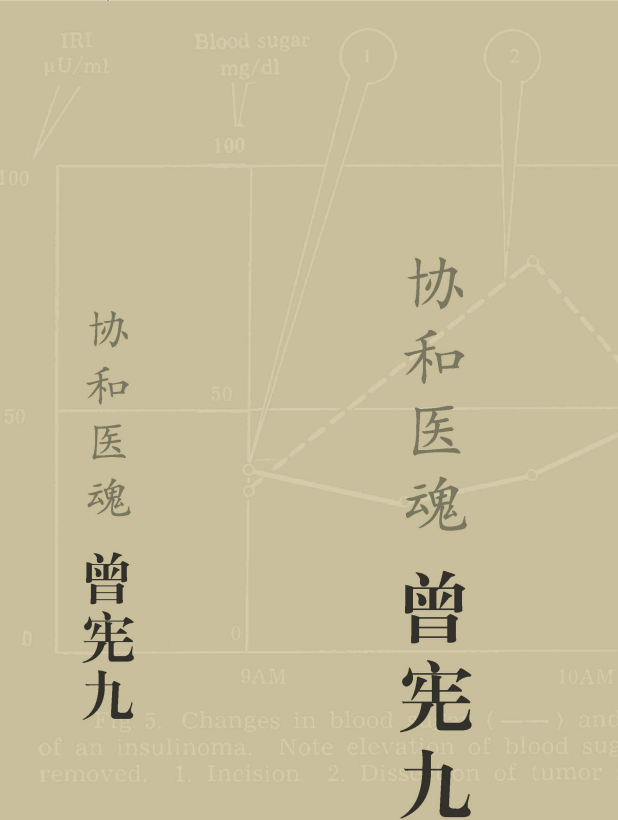


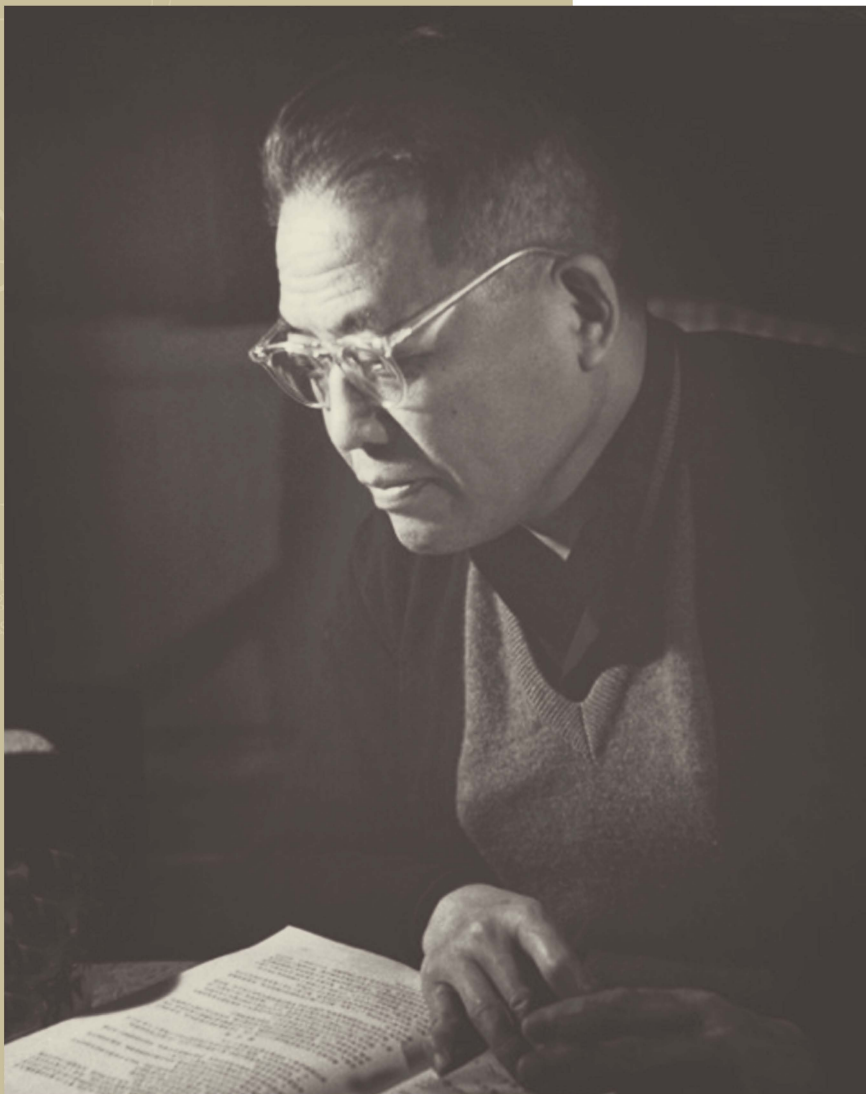


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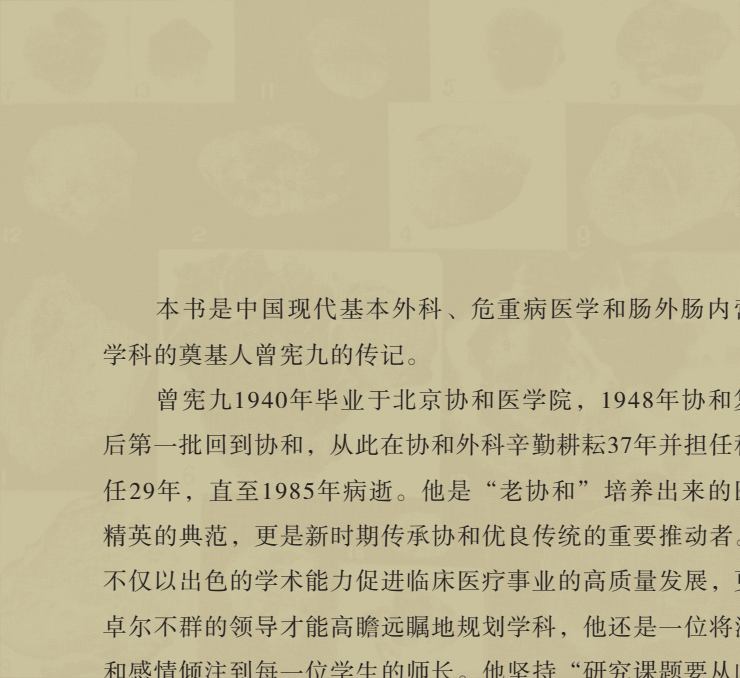
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本书是中国现代基本外科、危重病医学和肠外肠内营养学科的奠基人曾宪九的传记。

曾宪九1940年毕业于北京协和医学院，1948年协和复院后第一批回到协和，从此在协和外科辛勤耕耘37年并担任科主任29年，直至1985年病逝。他是“老协和”培养出来的医学精英的典范，更是新时期传承协和优良传统的重要推动者。他不仅以出色的学术能力促进临床医疗事业的高质量发展，更以卓尔不群的领导才能高瞻远瞩地规划学科，他还是一位将温暖和感情倾注到每一位学生的师长。他坚持“研究课题要从临床中来”，因而能在科学的春天到来之际，毅然决定协和外科以胰腺外科研究为主体，同时深入外科营养支持研究，并创建中国的危重病医学。

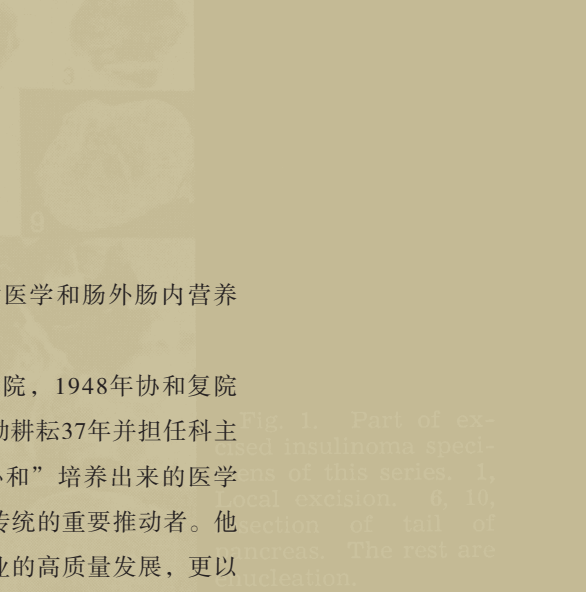
曾宪九的一生是中国现代外科学发展的缩影，也是中国一代高级知识分子追求真理、科学报国的共同命运的写照。他的身上集中了“协和式学者”的普遍特质：治学严谨、乐观向上、谦虚低调、淡泊名利，以医学事业为崇高使命。

中国现代基本外科依旧沿着曾宪九当年设定的轨迹发展前行。在呼唤信仰回归、呼唤大师出现的今天，让我们向这位逝去的长者致以崇高的敬意。

SURGICAL TREATMENT

The only effective treatment of insulinoma is surgical removal of the tumor or tumors (Fig 1). We have previously reported our experiences in the surgical treatment of insulinoma.¹⁻³ In this paper only some aspects based upon our more recent experiences will be emphasized.

Finding the tumor at the time of operation. The key to success in the operative treatment of insulinoma is to be able to find the tumor at the time of exploration, and the key to success in finding the tumor lies in a thorough overhauling of the pancreas as well as those regions where ectopic pancreatic tissue may exist. For this purpose, a good muscle relaxing anesthesia and an adequately large incision to expose the entire pancreas



Currently we prefer epidural anesthesia and transverse upper abdominal incision, while it is a midline incision. Large and superficially placed tumors are not difficult to find. In the case of the pancreas with the tumor, the index and middle fingers are used to palpate the pancreas. The key step in exploration is to find the tumor after mobilization of the pancreas. This is done by incising the peritoneum along the greater curvature of the stomach, as well as at the outer border of the pancreas. The consistency of the tumor is usually firmer than normal pancreatic tissue, thus it is often felt as a nodule with fairly well defined borders slipping under the palpating fingers. Any mass suspected to be insulinoma should be excised and immediately subjected to frozen section in order to confirm or refute the diagnosis. Among our 60 patients, the tumor was not found in 2 cases (3.3%). However, one tumor was subsequently revealed to be in the hilum of spleen when blind distal resection of the pancreas was carried out. The other tumor was found to be in the body of the pancreas at autopsy after death. The postoperative complications there should be avoided by finding these two tumors.

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Fig 5. Changes in blood sugar (—) and of an insulinoma. Note elevation of blood sugar removed. 1. Incision 2. Dissection of tumor.

hematoma is complete, divided small pancreatic ducts securely ligated, operative field clear, and damage to adjacent tissues minimized. There is, however, the following question of theoretical disadvantage: Is such a removal adequate when the tumor is malignant? Of course, if the tumor is grossly malignant, wide removal is indicated. Nevertheless in our patients with enucleation of the tumor, 13 had, on pathologic examination, evidences of conventional malignant criteria such as presence of invasion of capsule, fat or nerve and intravascular tumor thrombi.¹⁰ Of these 13 patients, 6 were operated upon within 2 years only, while the other 7 cases have been followed up for 16.5 years. One patient died of malignant lymphoma 16.5 years after operation, and the other 6 patients were living and well at the time of follow-up. These observations seem to ensure the safety of enucleation of insulinomas in spite of the presence of suspicious microscopic evidences of malignancy.

Management of no tumor found at the time of operation. There is still disagreement as to whether or not to perform a second operation if no tumor is found at the time of operation. We prefer controlled staged resection and right under blood sugar monitoring. The resected portion of the pancreas should be immediately sent for pathologic examination. At the same time, blood sugar is determined every 15 minutes. If a tumor is found in the resected portion, the operation is terminated. If not, the blood sugar becomes elevated or 80-90% of the pancreas is resected. In this way, the chance of removal

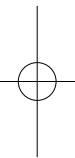
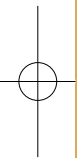
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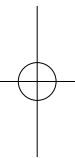
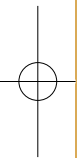


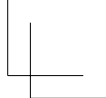
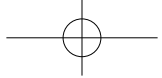
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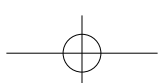
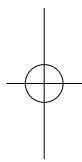
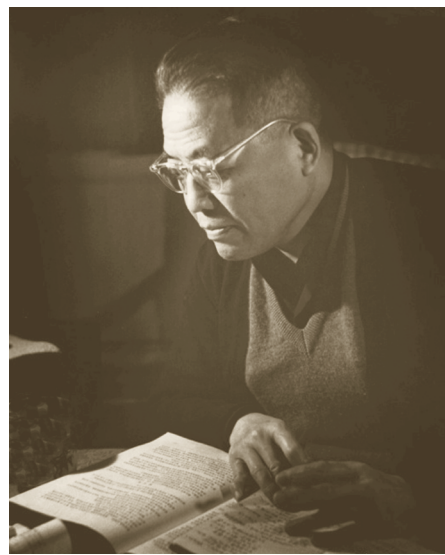


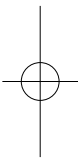
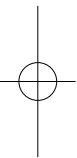




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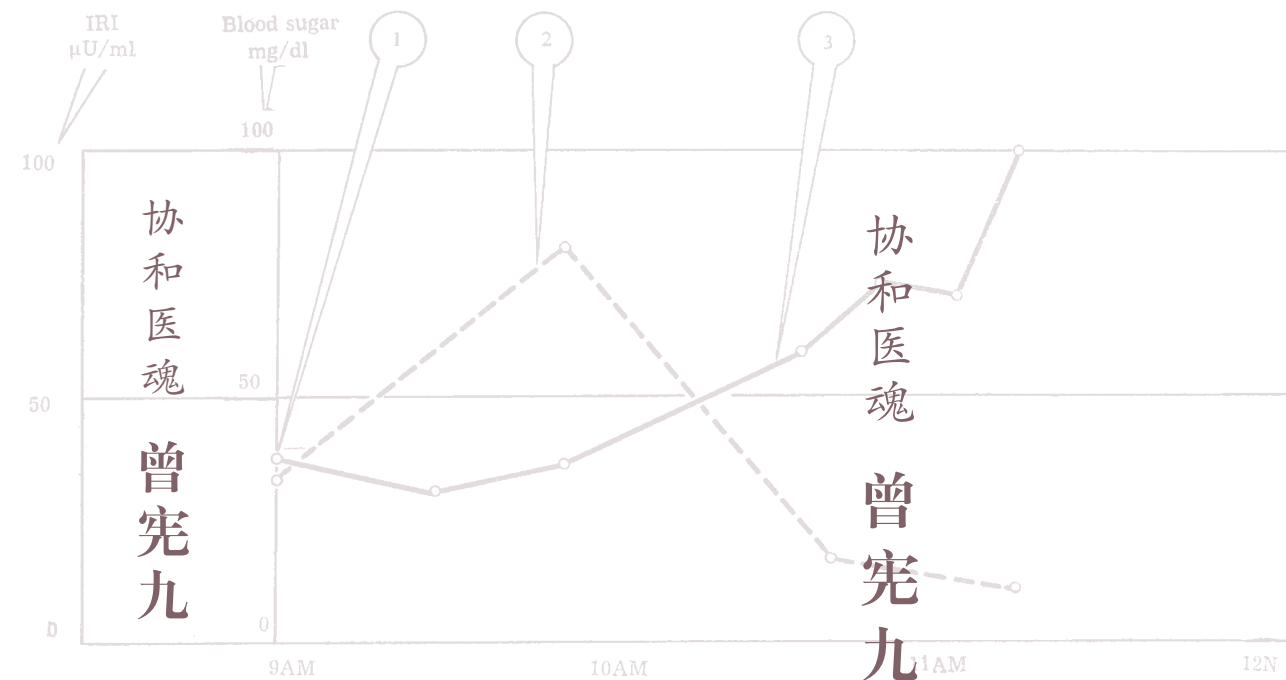
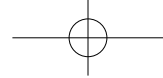


Fig 5. Changes in blood sugar (—) and serum insulin (----) during operative removal of an insulinoma. Note elevation of blood sugar and fall of serum insulin after the tumor was removed. 1. Incision 2. Dissection of tumor started. 3. Tumor removed.

oration. If these 6 cases are considered as agnostic errors, the diagnostic accuracy by hipple's triad would be 91%, while it is ite likely that some of these 6 cases of neg-ve exploration harbored unfound occult sulinomas. We are not impressed with e necessity of routine use of glucose toler-ge test, tolbutamide test, 1-leucine test, eagon test and other more sophisticated agnostic tests.

URGICAL TREATMENT OF INSULINOMA

The only effective treatment of insuli-ma is surgical removal of the tumor or nors (Fig 1). We have previously reported r experiences in the surgical treatment of sulinoma.⁶⁻⁸ In this paper only some as-cts based upon our more recent experiences ll be emphasized.

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are essential. Currently we prefer epidural block anesthesia and transverse upper ab-dominal incision. Large and superficially situated lesions are not difficult to find. Bimanual palpation of the pancreas with the thumb in front and the index and middle finger behind is the key step in exploration of deeply seated tumors after mobilization of the organ by incising the peritoneum along its inferior border as well as at the outer border of the duodenum. The consistency of the tumor is slightly firmer than normal pan-creatic tissue, thus it is often felt as a nodule with fairly well defined borders slipping under the palpating fingers. Any mass sus-pected to be insulinoma should be excised and immediately subjected to frozen section in order to confirm or refute the diagnosis. Among our 60 patients, the tumor was not found in 2 cases (3.3%). However, one tumor was subsequently revealed to be in the hilum of spleen when blind distal resection of the pancreas was carried out. The other tumor was found to be in the tail of the pancreas at autopsy after death of the patient from postoperative complications. With more ex-periences there should be little difficulty in finding these two tumors.

According to experiences obtained in the operative treatment of these 60 cases, the

hemastasis complete, divided small pan-creatic ducts securely ligated, operative field clear, and damage to adjacent tissues minimal. There is, however, the following question of theoretical disadvantage: Is such a removal adequate when the tumor is malignant? Of course, if the tumor is gross-ly malignant, wide removal is indicated. Nevertheless in our patients with enucleation of the tumor, 13 had, on pathologic ex-amination, evidences of conventional ma-lignant criteria such as presence of invasion of capsule, fat or nerve and intravascular tumor thrombi.¹⁰ Of these 13 patients, 6 were operated upon within 2 years only, while the other 7 cases have been followed up for 2-16.5 years. One patient died of malignant lymphoma 16.5 years after opera-tion, and the other 6 patients were living and well at the time of follow-up. These observations seem to ensure the safety of enucleation of insulinomas in spite of the presence of suspicious microscopic eviden-ces of malignancy.

Management of no tumor found at the time of operation. There is still disagree-

ment on this problem, but now more and more authors concur that random simple blind resection confined to the distal pan-creas is not a rational procedure as formerly believed. There were 9 simple random blind resections in our series (including one patient reoperated upon); in only one case was the tumor found in the hilum of spleen, a success rate of only 12.5%. This is not surprising as difficult-to-find occult tumors are more often located in the pan-creatic head and uncinate process. Fur-thermore a resection of such an extent is also not adequate in case of islet hyperpla-sia. We prefer controlled staged resection from left toward right under blood sugar monitoring. The resected portion of the pan-creas should be immediately sent for pa-thologic examination. At the same time blood sugar is determined every 15 minutes. If a tumor is found in the resected spec-imen and the blood sugar becomes elevated within 30 minutes (Fig 5), the operation is terminated, otherwise more of the pancreas is resected until the above results are obtain-ed or 80-90% of the pancreas is removed. In this way, the chance of removal of an

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序 言

今年是我国杰出的外科学家、医学科学家、医学教育家，中国现代基本外科重要奠基人曾宪九教授诞辰 100 周年。我们怀着无限敬仰的心情组织编写《协和医魂 曾宪九》，深切缅怀这位医学大师、医界楷模、外科老主任和老前辈。

曾宪九出生在内忧外患、民不聊生的中华民族危难时期，从小立志科学报国。他 1940 年毕业于北京协和医学院，是老协和培养的医学精英的代表。从 1956 年担任北京协和医院外科主任至 1985 年逝世，曾宪九教授在近 30 年的时间里，始终牢记协和先贤在医院创设之初设定的“世界一流的医院必须将临床医疗、医学教育及科学研究融为一体”的办院理念，并将这一理念融入到对外科业务发展、制度建设、学科规划及人才培养的整体安排中。在曾宪九教授的领导下，协和外科始终秉承了老主任泰勒、娄克斯等留下的协和要坚守最高质量标准的精神。凭着对国际外科学术前沿及发展方向的敏锐洞察，结合中国的医学实际及协和的定位与优势，曾宪九教授高瞻远瞩地布局学科，呕心沥血地培养人才，使协和始终保持了在新理论、新技术上的引领地位，甚至不遗余力地赶超国际水平。他为协和外科的发展，特别是中国追赶世界医学先进水平贡献了毕生的精力和心血，真正做到了鞠躬尽瘁、死而后已。

在学科布局上，曾宪九教授挑选基本外科中最具挑战性的胰腺外科，进行了长达几十年的全面探索和艰苦研究，取得了让国际同行钦佩的成就。在他的领导下，协和医院在国内率先创办了肠外肠内营养、重症医学

科、血管外科等新兴学科。直至今日，中国现代基本外科依旧沿着曾宪九教授设计的框架发展前行。曾宪九教授所处的时代艰苦而动荡，但这绝不影响他对科学的追求和对事业的执著，他抓住上世纪60年代上半叶国家稳定发展的“黄金时期”以及改革开放初期“科学发展的春天”两次大好机遇，带领协和外科两度攀登中国外科领域的学术巅峰。他以严谨的治学态度和大胆的创业魄力，树立了中国科学家创新思维驱动学科发展的典范。世界著名外科学家、哈佛医学院教授穆尔高度评价曾宪九的工作，“当‘文化大革命’结束后，中国立即在临床医学与外科领域爆发出广泛而强劲的力量。曾教授是这股力量的领导者。”

曾宪九教授重视外科医生临床思维的养成，强调一切从病人利益出发，从临床中发现问题，开展科学研究，以研究成果推进临床医学的发展进步，最终让病人获益。这一思路正是当下全球方兴未艾的转化医学研究的要义和精髓。由曾宪九教授倡导和领衔的胰腺疾病协作组，树立了中国开展疑难疾病多学科诊治MDT模式的典范。曾宪九教授一生钟爱教育事业，他从前辈及自身的成长体会到，一个好的制度安排和浓厚的学术空气对人才培养是多么弥足珍贵。因而在外科主任的舞台上，他不遗余力地恢复重建老协和的基本制度、传承协和的优良传统，为青年一代的成长提供需要的养分、土壤和空气。

提到曾宪九教授，人们最难以忘怀的是他独特的人格魅力。他以奋发有为的工作，乐观向上的态度，光明磊落的胸襟，淡泊名利、谦虚低调的作风，深深地吸引、教育和感染着身边的每一个人。他以海纳百川、知人善教、扬长避短、扶掖后学的大师风范，悉心栽培能接触到的所有同仁。许多人在回忆曾宪九教授时，都难忘这位善于选定方向并把大家组织凝聚起来成就伟业的师长，永远难忘曾宪九教授在他们人生转折的关键时期给予的扶持和激励。在大家心目中，曾宪九教授是外科的全才、将才和帅才，是真正的学者，是当之无愧的精神领袖。

当前，医院正处在迎接百年协和、加强内涵建设的关键时期。“重