The Moscow Institute of Proctology and the A.V. Vishnevsky Institute of Surgery.

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Letter to the Editor

To the Editor—Recently, I had an opportunity to visit the Soviet Union at the invitation of the Moscow Institute of Proctology and the A. V. Vishnevsky Institute of Surgery and wanted to share this experience with the readership of *Diseases of the Colon & Rectum.*

The Moscow Institute of Proctology, headed by Professor Gennady I. Vorobyov, was originally a municipal hospital. In 1971 it was reestablished as an institute, and by 1979 it had become a scientific research institute, the only one in the Soviet Union. The Moscow Institute of Proctology is a referral center housing 250 adult patients, with an additional 60 emergency beds in a nearby structure. Three thousand operations are performed each year and facilities are available for non-operative treatment.

The structure is divided into five floors with 50 beds in each department. The structure houses two general proctologic departments, oncoproctology for benign colonic disease including diverticular disease, and a special area for a surgical group that treats ulcerative colitis and Crohn's disease. Each year they perform about 40 operations for inflammatory bowel disease, 100 operations for colon cancer, 50 operations for megacolon (Hirschsprung's in adults), and 70 to 80 operations for "reconstruction" and sphincter-saving procedures. Myotomy is still a favored operation for diverticular disease. They perform 300 operations per year for rectal cancer and 40 to 50 procedures for familial polyposis. In total, as many as 800 anorectal operations may be performed each year.

Postgraduate education in the Soviet Union usually consists of one year of graduate training beyond medical school, after which the resident may elect to train in a subspecialty in surgery. Residents remain at the Proctologic Institute for about two to three years.

The hemorrhoidectomy is performed almost universally with spinal anesthesia and an open (Milligan and Morgan) technique. Patients are admitted three days before surgery and usually stay 10 days after surgery. The average stay for resection of the sigmoid colon is 20 to 25 days; patients are admitted approximately 10 days before the operation and stay for 14 to 16 days after surgery. The rate of anastomotic dehiscence is 5 to 6 percent.

The tour of the hospitals revealed a generally clean atmosphere, although the plumbing was less modern and less sterile than in hospitals in the United States. Most patients were in six-bed rooms with dividing curtains. There were no attached bathrooms in these particular wards, and there seemed to be little concern for privacy. Separate rooms were used for intramuscular injections, intravenous injections, and change of dressings. During lunch hour, the food trolley, about the size of a hot dog vendor's cart, was brought to each room, and the ambulatory patients lined up with bowls and plates. The patients and nurses were very polite, almost obsequious, and usually stood at attention when the physicians made rounds. The patients appeared to hold their surgeons in high esteem. The pace was generally much slower than the bustling tempo we are used to in busy general hospitals in the United States.

In the operating room the surgeon performed about 4 to 5 procedures each day. Surgery was not performed on Fridays, which were reserved for Grand Rounds, training strategies, and discharging so that patients would not have to stay over the weekend. The operating rooms at the Moscow Institute of Proctology were roomy and clean with large windows overlooking the River Moskava. Although concern for sterility was shown, there was no divider between the anesthesiologist and the surgeon, and there was minimal monitoring equipment. We had to change into scrub suits and wear surgical caps that resembled chef hats. They made cloth masks available to us, and we were asked to slip into casual slippers with long cloth shoe covers over them. One of the operations they were anxious to show was a partial hepatic lobectomy using a nitrogen gas knife, which seemed to provide very adequate hemostasis at the cut surface.

There has been considerable interest in the reconstruction of the perineum following abdominoperineal resection of the rectum for cancer. Dr. Tamara Odoriak has modified the Schmidt technique with 50 such procedures, 40 primary and 10 reconstruction procedures following a previous Miles' operation. The maximum period of follow-up of these patients is four years. We watched Dr. Odoriak perform the procedure with her team in a meticulous fashion. We were encouraged to examine a 42-year-old male truck driver who had undergone the procedure four months previously. The tight neosphincter, barely admitting a little finger yet relaxing on coaxing, was impressive. The patient claimed to be continent after having used irrigation daily, although he did wear a pad.

At the Institute, magnetic devices for anal incontinence and compression devices for intestinal anastomosis

(AKA-4) were being used. Researchers are currently studying the effectiveness of dialysis in ulcerative colitis. In one small cubicle a dialysis machine was set up to expose the blood to ultraviolet rays and then to return it to the patient's stream. They claimed good results following one treatment weekly for three sittings. They also had two hyperbaric chambers where there was similar exposure for one hour per week over a three-week period for chronic ulcerative colitis.

Professor Vladimir Federov is now head of the A.V. Vishnevsky Institute of Surgery. With 500 beds, this institute is the largest surgical specialty hospital in the country. It serves as a tertiary referral center for all Soviet states, but no open heart surgery or transplantation is performed there. We were shown selected patients on various floors: a total pancreatic-duodenectomy performed the day before, several plastic myocutaneous advancement flaps, radical mastectomies with immediate reconstruction, and advanced vascular surgical procedures. The Institute has a computed tomography scan but no magnetic resonance imaging. Absent were the computer terminals, monitoring devices, and technologic ancillary aids one takes for granted in hospitals in the United States. The hospital is certainly their showpiece, and the Soviets are very proud of it.

Our hosts treated us with overwhelming grace and generosity, and our discussions were open. The surgeons are hoping to enlarge the scope of these exchanges, with formal approval of the governments, to include all areas of surgery. A cooperative effort has been proposed in the management of inflammatory bowel disease and reconstructive procedures following cancer operations. We also talked about keeping a cooperative familial polyposis registry. I had suggested that they initiate a pelvic physiology laboratory, which does not yet exist in the Soviet Union.

New American-Soviet ventures in medicine show an unprecedented willingness on the part of physicians in both countries to learn from the successes and failures of two radically different health care systems. A program that promotes physicians working together to address common public health and surgical goals requires a degree of frankness rarely possible before Gorbachev and the era of Glasnost. In fact, it was openly stated that this interchange would not have been possible last year. It is hoped that a formal exchange between our two countries will better prepare both nations for medicine in the 21st century and will contribute to this new era of American-Soviet understanding.

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