

Prosthetic Esophageal Transmural Erosion After Mesh HiatoPlasty



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Introduction

Intrathoracic wrap herniation from crural repair break-down is a well recognized complication of Nissen fundoplication^{1,2}. To counter this problem, some surgeons recommend the use of mesh prosthesis to buttress the cruroplasty, both for open and laparoscopic hiatal repair². Schols and Richards have strongly cautioned the use of mesh because of concerns of erosion and stricture³. In the adult population, there are reports of up to 26% intrathoracic wrap migration rate after laparoscopic fundoplication and up to a 41% recurrent rate after laparoscopic paraesophageal hernia repair². There are five reports in literature of mesh erosion after hiatal repair³.

Case Report

Identification

Female
68 years old,

Past medical history.

Asthma

History of present illness

She was submitted to anti-reflux surgery through laparoscopic (Nissen fundoplication) for hernia of the esophageal hiatus (type I). One year after the first surgery, for received hernia of the esophageal hiatus, the patient was submitted to laparotomy with placement of politetrafluoroetileno (PTFE) prosthesis peri-esophageal and splenectomy by iatrogeny. Eight months after the last intervention, it falls back upon emergency room of São Marcos Hospital for dysphasia (for solids and liquids).

Complementary examination

She accomplished high digestive endoscopy that revealed transmural migration (Fig. 1) of the prosthesis into the distal esophageal lumen; Endoscopic extraction of the prosthesis was not possible.

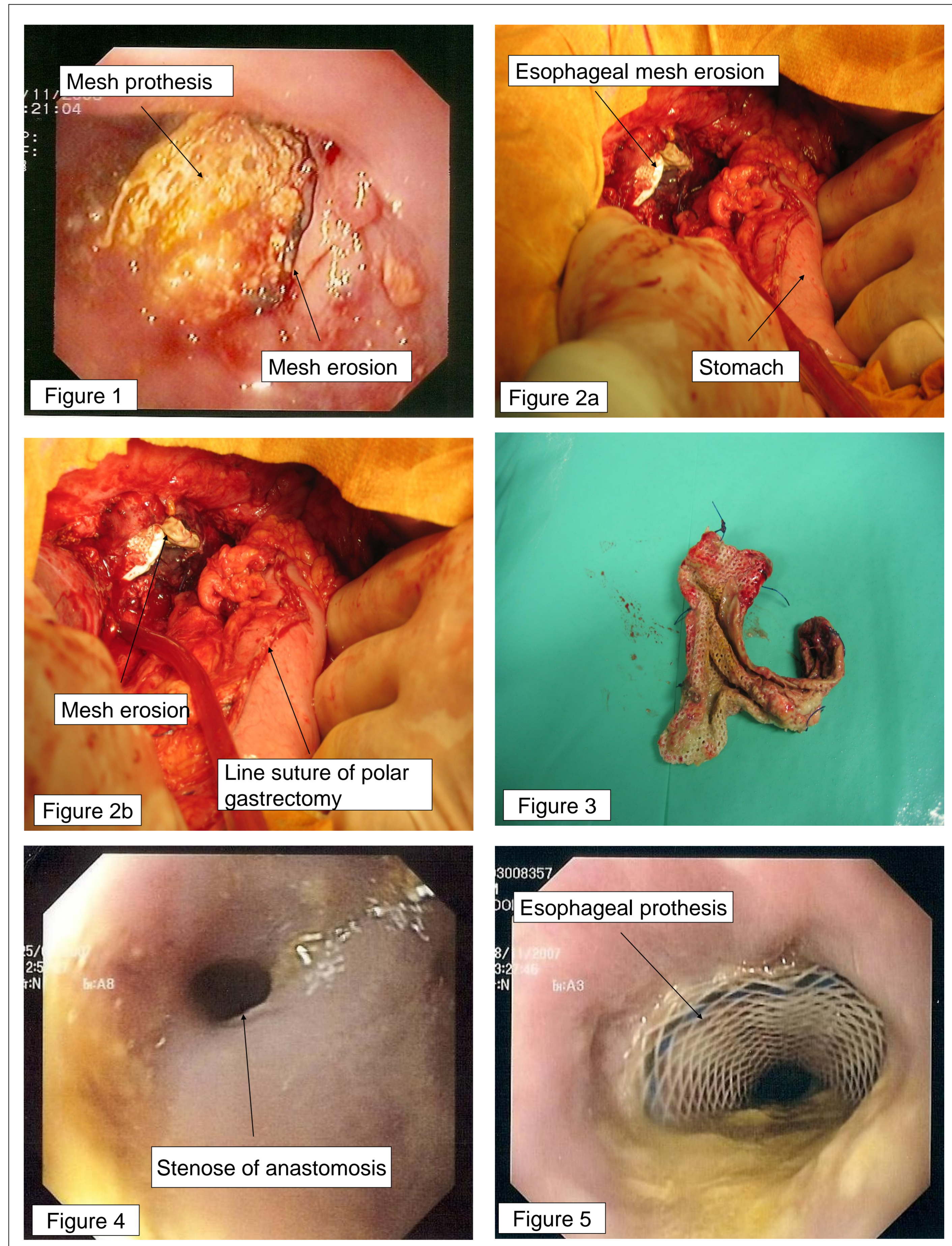
Surgical treatment

Surgical correction in two times:

First time with prosthesis extraction (Fig. 2a, 2b e 3) and sub-total esophagectomy with esophageal exclusion, cervical esophagostomy and jejunostomy for feeding;
Second time almost total esophagectomy with retroesternal esophagocoloplasty.

Evolution

She was discharged home 41 days after the last surgery. Having developed a mild stenosis (Fig.4) of esophagoileocolic anastomosis, endoscopic dilatations and endoluminal prosthesis became necessary (Fig. 5).



Conclusion

The problem of esophageal mesh erosion must be approached surgically. Endoscopic removal should be attempted but may be unsuccessful if the mesh is well anchored in the esophageal wall. Although it is usually expected that extensive esophagogastric resection and reconstruction will be required.

References

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