شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم

شبكة المعلومـــات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

جامعة عين شمس

التوثيق الالكتروني والميكروفيلم

﴿ قَسَـــم ﴾

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
علي هذه الأفلام قد اعدت دون آية تغيرات

يجب أن

تحفظ هذه الأفلام بعيداً عن الغبار

في درجة حرارة من 15 – 20 مئوية ورطوبة نسبية من 20-40 %

To be kept away from dust in dry cool place of
15 – 25c and relative humidity 20-40 %

بعض الوثائق الأصلية تالفة

بالرسالة صفحات

لم ترد بالأصـــل

THORACOSCOPY AND PLEURODESIS IN MALIGNANT PLEURAL EFFUSION

Thesis

Submitted for partial fulfillment of M Sc. Degree

In Generl Surgery

By

AMR AHMAD MOSTAFA AZIZ

(M. B., B. Ch)

Supervised by

Dr.

ABD EL AZIZ ABBAS TAALB

Assist. Prof. of General surgery

Faculty of Medicine

Menoufiya University

Dr.

AHMED LABIB DOKHAN

Lecturer of cadiothoracic surgery

Faculty of Medicine

Menoufiya University

Faculty fo medicine

Menoufiya University

1994

THORACOSCOPY AND PLEURODESIS IN MALIGNANT PLEURAL EFFUSION

Thesis

Submitted for partial fulfillment of M Sc. Degree

In Generl Surgery

By

AMR AHMAD MOSTAFA AZIZ

(M. B., B. Ch)

Supervised by

Dr.

ABD EL AZIZ ABBAS TAALB

Assist. Prof. of General surgery

Faculty of Medicine

Menoufiya University

Dr.

AHMED LABIB DOKHAN

Lecturer of cadiothoracic surgery

Faculty of Medicine

Menoufiya University

Faculty fo medicine

Menoufiya University

1994

To

My Parents

Contents

ACKNOWLEDGEMENT

Firstly, thanks to God for giving me the courage, health and patience to undertake and accomplish this thesis.

I would like to offer my all deep thanks to ***Prof. Dr. Shawki Shaker*** Professor and chairman of Surgery, Faculty of Medicine, Menoufiya University, for his sincere and helpful guidance. Throughout the study.

My very indebteness to ***Prof. Dr. Abdel-Aziz Abbas Taalb.*** Assist. Professor of general surgery, Faculty of Medicine, Menoufiya University. For his constant support, valuable directions and objective criticism made the accomplishment of this study possible.

My very deep indebtness and very gratefulness to ***Dr. Ahmed Labib Dokhan.*** Lecturer of cardiothoracic surgery. Faculty of Medicine Menoufiya University. Who devoted so much of his precious time, generous support, close supervision, objective criticism made the accomplishment of this study possible.

My thanks , indebtness and gratitude go to both ***Dr. Mahmoud Badawy , and Dr. Said El-Mallah*** Assistant Professors of general surgery , Faculty of Medicine , Menoufiya University, for their help and guidance during preparation of this thesis .

My very deep indebtness to ***Prof. Dr. Mamdoh Mohamd Radown.*** Assist. Professor of pathology. Faculty of Medicine, Menoufiya University, for his guidance and appreciable great

assistance by reading the pathology slids.

My very deep indebtness and very gratefulness to ***Dr. Osama Fahim***, Lecturer of chest disease. Faculty of Medicine, Menoufiya University,for his generous support, valuable aduises, and useful discussion throughout this work.

My very deep indebtness and very gratefulness to ***Professor Dr. Amr Helmy***, Professor and chairman of surgery, and ***Dr. Ibrahim Marawan***, Assistant Professor of surgery, and ***Dr. Talaat El-Sefi***, Lecturer of surgery, ***Dr. Hesham Gad,*** Lecturer of surgery, liver institute , Minoufiya University for their generous help and guidance during preparation of this thesis.

Introduction

Thorcoscopy and pleurodesis in malignant pleural effusion

Introduction

One of the most common diagnostic problems encountered by chest physicans and surgeons is the presence of fluid in the pleural space. Sometime, the cause of the pleural effusion is obvious, such as that associated with congestive heart failure, but whatever the cause, fluid in the pleural space requires investigations because it may represent serious and possibly fatal disease often the discovery of the cause is elusive and presents a difficult diagnostic challenge. The incidence in which evaluation of pleural fluid results in , no diagnosis, presents 1-3% of cases. Therefore diagnostic efforts must be determined in the hope of arriving at a specific diagnosis *(Storey et al., 1976)*.

Thoracoscopy was introduced by Jacobaeus in 1910 as a diagnostic procedure. During the era of pulmonary collapse therapy of tuberculosis, it was used mainly for the lysis of pleural adhesions. Recently, there has been a renewed interest in this method, mostly for establishing the aetiology of pleural effusion *(Weissberg and Kaufman, 1980)*.

Malignant pleural effusion occurs in as many as 50 percent of patient with cancer at some point in the course of their disease ***(Reshad et al., 1985)***. The most common malignancies were lung, breast and unknown 1ry carcinomas ***(Martinez et al., 1993)***. From 28 % to 61 % of effusions seen in a general hospital are malignant, and up to half of patients with breast cancer will develop an effusion during the course of their illness ***(Hausheer and Yarbro, 1985)***.

Malignant pleural effusion is a significant cause of morbidity in patients with advanced cancer. Although the quantity of patients lives is more often determined by the progress of their systemic cancer, the quality of their lives can be inproved significantly by successful management of their effusions ***(Ruckedeschel, 1988)***.

Tube thoracostomy with subsequent chemical pleurodesis is the treatment of choice for patients with tumors that are relatively insensitive to systemic chemotherapy ***(Moores DW 1991)***.

Tetracycline in conjunction with thoracoscopic drainge is currently considered as the optimal sclerosing agent due to its high efficacy, good patient tolerance, simple and repeatable applicability and low cost of treatment ***(Frank et al., 1989)***. With the resurgence of thoracoscopy, there is renewed interest in less invasive methods of pleurodesis ***(Bresticher et al., 1993)***.

Aim of the work