



شبكة المعلومات الجامعية

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ



شبكة المعلومات الجامعية
@ ASUNET



شبكة المعلومات الجامعية التوثيق الالكتروني والميكروفيلم



شبكة المعلومات الجامعية

جامعة عين شمس

التوثيق الالكتروني والميكرو فيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
علي هذه الأفلام قد أعدت دون أية تغيرات



يجب أن

تحفظ هذه الأفلام بعيدا عن الغبار

في درجة حرارة من ١٥-٢٥ مئوية ورطوبة نسبية من ٢٠-٤٠%

To be Kept away from Dust in Dry Cool place of
15-25- c and relative humidity 20-40%

بعض الوثائق الأصلية تالفة

بالرسالة صفحات لم ترد بالاصل

LAPAROSCOPIC MANAGEMENT OF GASTRO-
OESOPHAGEAL REFLUX DISEASE PROCEDURES

25/11/06

Essay

*Submitted for Partial Fulfilment of
Master Degree in General Surgery*

By

Ahmed Mohamed El Shaer

M.B.B.Ch of Medicine, Ain Shams University

Supervised By

Prof. Dr. Nabil Shedid

Professor of General Surgery
Faculty of Medicine
Benha University

Prof. Dr. Essam Sadek

Professor of General Surgery
Faculty of Medicine
Benha University

Dr. Mostafa Saleh


Lecturer of General Surgery
Faculty of Medicine
Benha University

Faculty of Medicine

Benha University

2006





بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

وَقُلْ رَبِّ زِدْنِي عِلْمًا

صدق الله العظيم

سورة طه : آية (١١٤)

Acknowledgement

First I thank **GOD** the most helpful and the most merciful.

I would like to express my inner feeling of thankfulness and sincerity for **Prof. Dr Nabil Shedid**, for his help and advises.

Also I hope to success in thanking and showing may appreciation for **Prof. Dr Essam Sadek**, for spending much time in supervision assistance patience an guidance in the review.

Finally I thank **Dr Mostafa Saleh** for his cooperation in this work.

List of Contents

Title	Page No.
Introduction and aim of the work	1-3
Anatomical consideration	4-25
Physiological considerations	26-31
Pathology of GERD	32-40
Diagnosis of GERD	41-62
Investigations	63-89
Treatment	90-169
Summary	170-172
References	173-194

List of Figures

Fig. No.	Title	Page No.
Fig. (1):	Topography and constriction of the oesophagus	5
Fig. (2):	Relation of the abdominal part of the oesophagus	11
Fig. (3):	Arterial supply of the esophagus	12
Fig. (4):	Venous supply of the esophagus	14
Fig. (5):	Lymphatic drainage of the oesophagus	16
Fig. (6):	Anatomy of the diaphragm (Thoracic part)	17
Fig. (7):	Anatomy of the diaphragm (Abdominal part)	18
Fig. (8):	Gastroesophageal junction	24
Fig. (9):	Evaluating symptoms in oesophageal disorders	64
Fig. (10):	Normal manometry	80
Fig. (11):	Position of the reflux operations	116
Fig. (12):	Transabdominal open nissen fundoplication	118
Fig. (13):	A transthoracic mobilization of the stomach and esophagus	119
Fig. (14):	Transthoracic open Nissen fundoplication	121
Fig. (15):	Floppy Nissen fundoplication	123
Fig. (16):	Belsy Mark IV procedure	127
Fig. (17):	Collis gastroplasty	128
Fig. (18):	Hill posterior gastropexy	130
Fig. (19):	Toupet fundoplication	132
Fig. (20):	Operating room layout for laparoscopic antireflux	139
Fig. (21):	Port locations for laparoscopic antireflux surgery	140
Fig. (22):	Laparoscopic Nissen fundoplication	142
Fig. (23):	Technique of laparoscopic antireflux surgery	145

List of Tables

Tab. No.	Title	Page No.
Table (1):	Results of laparoscopic antireflux surgery LARS	150
Table (2):	Reasons for failure of the primary antireflux repair in 63 patients requiring surgery	156



Introduction and Aim of the Work

INTRODUCTION

Gastro-oesophageal reflux disease (GERD) is the medical term for chronic heartburn. Many people have heartburn at times it's caused by irritation from stomach acid that backs up into the oesophagus. The oesophagus is the tube that carries food from your mouth to your stomach sometimes stomach acid backs all the way up to the throat or into the mouth. This acid has a sour taste (*Fennerty, 2000*).

The simplest approach is to define the disease by its symptoms. However, symptoms thought to be indicative of GERD, such as heart burn, acid regurgitation, are very common in general population and many individuals consider them to be normal and do not seek medical advice (*Kahrijas, 2001*).

GERD can usually be diagnosed based on the clinical presentation alone. In some patients, however, the diagnosis may require endoscopy and, ambulatory pH monitoring. Management includes lifestyle modifications and pharmacologic therapy, refractory disease requires surgery the therapeutic goals are to control symptoms, heal esophagitis and maintain remission so that morbidity is decreased and quality of life is improved (*Velanbvich, 2001*).

Patients who did not respond well to lifestyle changes and drug therapy, especially those with grade three and four oesophagitis, and the young age group, should be treated surgically. Reduction of the hiatus hernia if present, repair of the oesophageal hiatus and fundoplication is a surgical procedure that has stood the test of time. However, the traditional open procedure requires a large incision and along, painful recovery (*Spechler, 2001*).

Laparoscopy has dramatically changed operations for gastroesophageal reflux disease (GERD), making them increasingly common in the last decade. As experience with laparoscopic antireflux procedures has increased, operating times, conversion rates, postoperative complications, and hospital length of stay have all decreased. Through long term outcomes data are not yet available, it is clear that the laparoscopic approach to this procedure is equally effective compared with the open approach. In addition, the benefit to the patient in terms of postoperative recovery is indisputable (*Flipi and Lehman, 2001*).

AIM OF THE WORK

The aim of this study is review the literature and highlight update in diagnosis and treatment of gastro-oesophageal reflux disease (GERD regarding medical and surgical treatment with special stress on laparoscopic techniques. Evaluation of different ways for this technique will be discussed and correlated.