

Session VIII, Thorax I

SVIII1: CLOSURE OF THE THORACIC DUCT FROM THE LEFT SIDE ACCESS: A CASE REPORT- VIDEO PRESENTATION

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Background Chylothorax is associated with high morbidity and mortality due to drainage of a large amount of lymphatic fluid. Accumulation of chyle in the pleural cavity may be either a congenital condition or the result of acquired diseases. Conservative management associated with withdrawal of enteral nutrition or administration of analogs of sandostatin requires a long treatment duration, and in many cases, it is non-effective. Surgical management, like clipping the thoracic duct or pleurodesis of the pleural cavity, is a good option, especially when performed thoracoscopically. Minimally invasive surgical access is well tolerated by patients and produces effective results with a quick resolution of symptoms. Right thoracoscopy, in almost all reported cases, is the procedure of choice because of direct access to the thoracic duct. However, in the case of a left sided chylothorax, there is a connection with the opening of the contralateral pleural space. We present access to the thoracic duct via left thoracoscopy, which, in our opinion, may be a good alternative in the case of a left side chylothorax.

Materials and methods We report a 16-year-old patient with a massive left sided chylothorax after chemotherapy due to mixed germinal tumour of the testis with massive metastases located in the retroperitoneal space and posterior mediastinum. Chemotherapy resolved the metastases in the mediastinum but evoked a huge pleural effusion in the left pleural cavity, requiring surgical intervention. Left sided access was used. The 5 mm camera and three 5 mm working ports were inserted. The parietal pleura was incised and the oesophagus located and protected. Behind the oesophagus, the thoracic duct and concomitant tissue were clipped with titanium clips, and additionally, thrombin glue was used. Stopping of the lymph leakage was observed during surgery. A local argon pleurodesis was used to finish the procedure. The thoracic tube was removed on the third postoperative day.

Results The patient finished treatment three years ago and is now in a good general condition without any signs of recurrent disease, both in the abdomen and in the chest.

Conclusions Left side access may be a good alternative in the left sided chylothorax, but the crucial points are location and protection of the oesophagus during the procedure, which is also the landmark that allows for locating the thoracic duct.

Key words chylothorax, thoracoscopy, left sided access