Gastroesophageal Reflux Disease and its surgical management is the topic of our next General Surgery Case Report.

A 50 year old man presents to his physician complaining of recurrent severe substernal burning after eating spicy foods. Lately he has been awakened at night with regurgitation of stomach contents. The patient is asked to avoid meals after 6pm and to avoid alcohol which always makes his reflux worse. He is prescribed an H2 blocker and is referred to a gastroenterologist for further evaluation. The patient's endoscopy reveals esophagitis as well as Barrett's esophagus. An esophageal manometry is performed in anticipation of surgical referral which shows normal peristalsis in the body and normal pressures in the lower esophageal sphincter. The patient continues to have significant symptoms despite aggressive medical management.

Most patients with **Reflux Disease** can be managed medically, however in those patients with continued symptoms, especially nocturnal volume regurgitation, a surgical referral is reasonable. We perform all of our reflux operations laparoscopicaly. The procedure is done under general anesthesi , operative time is about 60 to 90 minutes. During the procedure any diaphragmatic hernia is dissected and reduced, making certain that the gastoesophagel junction is within the peritoneal cavity. The diaphragmatic hiatus is closed posteriorly using laparoscopicaly placed sutures. In some patients with very weak muscle tissue, a reinforcing layer of coated mesh is required. Most patients with reflux have normal motility and can undergo a 360 degree Nissen fundoplication. A minority of paitients have poor motilit , in these a partial 270 degree or Toupe fundoplication is performed.

Usually patients that have undergone Laparoscopic fundoplication can be discharged the morning after surgery. They are instructed to continue a soft diet. Patients with severe esophagitis are kept on proton pump inhibitors for six weeks and then taken off the medication. Some studies have shown arrest of progression of disease in those with

Charles Livingston MD FACS
Austin Surgeons PLLC Suite 200, 3901 Medical Parkway Austin , Texas 78756
512 467 7151 fax 512 467 8809 austinsurgeons.net

Barrett's esophagus who have undergone reflux surgery, follow up endoscopy is required in these patients.

The majority of patients (95%) who have undergone laparoscopic fundoplication report that their reflux symptoms of burning and regurgitation are corrected. Transient dysphagia occurs in 15% and resolves within 2 weeks. Recurrence of symptoms does occur in about 8% of patients usually due to breakdown of the repair at the hiatus secondary to large hiatal hernias and weak muscular tissue. In those patients that we identify as having weak tissue at the initial operation reinforcing coated mesh is used ; likewise in recurrent hiatal hernias the use of coated mesh reduces the risk of recurrence substantially. Mesh that is used to reinforce the diaphragm is coated with an absorbable material that works to prevent the rare complication of mesh erosion.

The vast majority of patients undergoing laparoscopic fundoplication are cured of their symptoms and no longer take medication for it. For detailed data regarding my results with this procedure please reference my published manuscript **Laparoscopic Hiatal Hernia Repair 2001 vol 67, pg 987-991 in *The American Surgeon***, or request a reprint from our office. We would be happy to discuss it with you at any time.

I hope this has been informative. Please don't hesitate to call me to discuss surgical disease and treatment.

Thanks
Charles Livingston M.D. FACS

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