Negative Pressure Therapy for the Treatment of Inguinal Lymphatic Fistula

Terapia con presión negativa para el tratamiento de fístula linfática inguinal

Lymphatic complications after surgery in the inguinal region are attributed to the injury of small lymphatic vessels. Despite efforts to prevent damage, the incidence of lymphorrhrea currently reported after these procedures is around 2%. Several therapeutic options have been described with varying degrees of success, and the experience of vacuum therapy in this field is limited.

We present the case of a 75-year-old male with type II diabetes, dyslipidemia and benign prostatic hypertrophy who came to our consultation due to an increased abdominal perimeter and poly-lymphadenopathy syndrome. Under local anesthesia, we resected a right inguinal lymph node measuring 4 cm in diameter. The pathology study confirmed the diagnosis of diffuse large B-cell lymphoma that was rich in T cells, and chemotherapy was initiated.

Seven days after the intervention, we observed an elastic tumor formation in the surgical wound that was non-pulsatile, showed no signs of inflammation, was painful and produced a mild serous exudate. It was drained and gauze was placed in the wound with an adhesive collection bag. Ten days later, there was continuous discharge of about 300 ml per day of clear liquid, which made us suspect the presence of a lymphatic fistula. Initially, conservative treatment was started with a compression bandage and rest. However, given the persistently high discharge volume 40 days after surgery, we decided to re-operate. During this operation, we found no evidence of any leaks or the supposedly injured lymphatic duct, and closure of the wound was performed with transfixon sutures.

Forty-eight hours after reoperation, the wound once again appeared tense with a clear exudate. We therefore decided to re-open it and implement a negative-pressure wound therapy system made with gauze, a 16 French suction catheter and adhesive sterile dressing, as shown in Fig. 1. Continuous suction at ~10 mmHg was applied. After 6 days of treatment with a gradual decrease in discharge until cessation, the vacuum system was withdrawn and the wound was almost entirely closed, with good granulation tissue and no exudate.

Fig. 1 – Vacuum system applied to the inguinal wound.

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Generally, based on their description, it was impossible to identify or extract meaningful natural text from the image. The text appears to be part of a scientific or medical discussion, possibly discussing lymphatic complications and their treatment. However, without clearer visibility or a larger image, it's challenging to extract specific content or context from the text in the image.

Carla Basés Valenzuela*, Marcos Bruna Esteban, José Puche Pla
Servicio de Cirugía General y del Aparato Digestivo,
Consortio Hospital General Universitario, Valencia, Spain

*Corresponding author.
E-mail address: carlajcf@hotmail.com (C. Basés Valenzuela).

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Treatment of Symptomatic Focal Nodular Hyperplasia by Arterial Embolization

Embolización arterial como tratamiento de la hiperplasia nodular focal sintomática

Focal nodular hyperplasia (FNH) is the second most common benign liver lesion after hemangioma. It represents 8% of all benign liver lesions and is more common in women between the ages of 30 and 50. Its diagnosis is usually incidental during testing for other pathologies.1

Conservative treatment has been well established in the cases of asymptomatic lesions due to their low risk of hemorrhage or malignant degeneration.

Lesions larger than 4 cm may cause abdominal pain by compressing neighboring organs, hemorrhage or distension of Glisson’s capsule. Surgery could therefore be indicated,2 but the surgical risk may be greater than any potential benefits. Transarterial embolization (TAE) of these lesions can be considered a less invasive, less risky alternative to surgical treatment.3

We present two cases where TAE has been effective in the treatment of abdominal pain caused by hepatic FNH.

Case 1

The patient was a 31-year-old woman who had been taking oral contraception for the previous 10 years and presented with multiple episodes of abdominal pain that limited her daily activities. A radiology study discovered a space-occupying lesion (SOL) in segment VI measuring 4.8 cm×4.1 cm (Fig. 1A) compatible with FNH. Work-up and tumor marker levels were normal.

After failed pain management treatment and psychiatric pathologies had been ruled out, the patient was re-evaluated. We decided to perform TAE (Fig. 1B), which provided optimal results. Three months later, the patient continued to be asymptomatic and CT reported a partially necrotized SOL measuring 3 cm (Fig. 2).

Case 2

The patient was a 35-year-old woman who had taken oral contraception for 5 years. She complained of abdominal pain that had been developing over several months and caused repeated visits to the emergency room. Radiological tests showed a SOL in segment VI measuring 5.8 cm×3.6 cm that was compatible with FNH.

During follow-up, progressive growth of the lesion was observed, which grew to 6.8 cm×6.8 cm, with persistent pain despite treatment with analgesia.

TAE has been able to completely control the pain to date, in spite of the maintained lesion size in successive follow-up control tests.

The origin of FNH can be a hyperplastic response of the hepatocytes to arterial injury or hyperperfusion or a preexisting vascular malformation.1

Pathologically, the lesions are usually solitary, with a size between 3 and 5 cm. The macroscopic appearance is that of a firm tumor formation, with a color similar to the surrounding

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