Reoperative antireflux surgery

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The long-term results of modern antireflux surgery are excellent. A failure rate of 10–20% over a long period of time, however, has been recorded with all operations currently undertaken. The majority of these failures occur in the first 2 years after operation. The commonest cause is recurrence of the original problem, i.e. recurrent reflux. In a smaller proportion of patients, there may be new problems such as dysphagia or chronic abdominal pain.

The requirement of reoperative surgery therefore falls into two categories. First is the management of patients with recurrent reflux. The decision for further surgery is here based on exactly the same criteria as for primary antireflux surgery, i.e. either intractable oesophagitis or complications from the reflux as described in the chapter on pp. 292–293. In this group of patients the aim of surgery is the same as in primary reflux disease, but the technique for achieving that aim may have to be modified. Second, there is the much smaller group of patients in whom the reason for further surgery is related to a complication of the surgery itself. This may be:

1. Dysphagia – the repair may have been made too tight, the oesophagus may be adynamic above a total wrap, or the hiatus may have been narrowed excessively by sutures.
2. Bloating after meals. It is very uncommon for this symptom to be so severe that it is necessary to undo a previous wrap.
3. Chronic postprandial pain syndrome. This occurs infrequently, but is sometimes a difficult problem.

On occasions a gastric ulcer is found in the region of the fundoplication, or a paraoesophageal hernia associated with the fundic wrap. Often no cause for the pain is found. In this situation the surgeon should only reoperate when a gastroenterological colleague, and possibly a psychiatrist, are in agreement that the patient's pain is apparently related to the previous surgery. When no overt cause for pain is found at operation, the surgeon has little alternative but to take the wrap down and substitute some other procedure, e.g. a partial fundoplication. Even with this cautious approach it should be stressed to the patient that the likelihood of a successful outcome is low.

Principles and justification

Early in the author's career it made good sense to operate via a previously unoperated approach. Thus, if the patient had previously undergone operation via an abdominal approach, the operation was carried out using the thoracic approach, or vice versa. Increasingly, the author has used the abdominal approach even when the previous surgery has been from the abdomen. This approach causes considerably less morbidity than a thoracic approach and also provides better access to the often dense adhesions associated with recurrent problems in this area. This approach will therefore be described here.
Operation

Incision

An upper midline incision is used. The findings in the region of the oesophageal hiatus are quite unpredictable. Sometimes it is almost as if no previous surgery has actually been carried out. At the other end of the spectrum are patients who have had some form of associated surgery, e.g. proximal gastric vagotomy, antiobesity surgery, or myotomy. In these patients the lesser curve is densely adherent to the liver, and there are other fibrous adhesions in the region. Whatever the circumstances, it is best first to define the upper limit of the dissection by seeking the oesophagus. A nasogastric tube should be passed to aid in this identification.

If adhesions are particularly dense in the region, the oesophagus is best approached by incising the diaphragm above and anterior to the hiatus and entering the thorax immediately proximal to the hiatus. It is then usually a relatively simple matter to mobilize the oesophagus and place a sling around it.

It is also important to mobilize the whole of the oesophagus distal to this point, the gastro-oesophageal junction and the upper stomach. This is done anteriorly by dividing adhesions from the stomach to the liver and diaphragm, using sharp dissection. Posteriorly, the lesser sac is entered and the stomach is dissected free from the pancreas and retroperitoneal tissues.