

## **Lymphoceles complicating arterial reconstructions of the lower limbs: outpatient conservative management.**

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**BACKGROUND:** Treatment of lymphoceles complicating vascular procedures is controversial. The purpose of this study was to evaluate the practicability, effectiveness and safety of conservative management on an outpatient basis. **METHODS:** Medical records were reviewed for 23 postoperative lymphoceles (in 18 patients) seen at our institution between 1986 and 1999. Diagnosis was made by physical examination and needle aspiration of fluid collection; bacterial cultures were obtained in all. Ultrasonography was performed in all patients, lymphoscintigraphy (99mTc HSA) in 11, angio-TC in 2 cases, MRI in 3 large lymphoceles. **RESULTS:** Twenty-one lymphoceles developed in the groin, 2 in the thigh and were mostly (72.2%) diagnosed after hospital discharge. Imaging techniques detected subcutaneous wound collection; in addition, lymphoscintigraphy showed lymphatic interruption and collateral pathways in patients with limb swelling. Outpatient management consisted of limited ambulation, limb elevation and pressure dressings; no serial aspirations were made. Resolution was obtained in all patients over a mean period of 21 days (range, 12 to 35). No patient required re-hospitalization or developed wound and/or graft infection. No recurrence was noted after a follow-up of all patients for 1 year. **CONCLUSIONS:** Outpatient treatment of lymphoceles following arterial reconstructive procedures can be performed safely. Significant advantages of this pathway include no re-hospitalization and cost reduction.

## **Management of lymph fistula in the groin after arterial reconstruction.**

**Kwaan JH, Bernstein JM, Connolly JE.**

Leakage of lymph from the inguinal incision is a rare but disturbing complication of arterial surgery. This article describes our experience in the management of 12 patients in whom lymphorrhea developed following arterial reconstruction. Seven patients were treated with pressure dressings, antibiotics, and immobilization. In this group, fistula healing was delayed up to four weeks, and wound infection occurred in three of seven patients. One patient eventually required removal of the prosthetic graft and below-knee amputation. Early groin reexploration and direct ligation of ruptured lymphatics was performed in the remaining five patients. Hospitalization was shortened and wound infection prevented in all patients in this group. We recommend prompt operative closure as the preferred approach in the management of lymph fistula following vascular reconstruction, especially when synthetic graft material is present.

## **Persistent lymphatic fistula. Unusual complication of femoro-femoral arterial bypass.**

**Sethi GK, Scott SM, Takaro T.**

An unusual complication of persistent lymph fistula occurred three months postoperatively following axillo-femoral and femoro-femoral bypass graft. The lymphangiograms demonstrated the precise site of lymph extravasation. Multiple aspirations and local drainage were of no avail and it finally responded to prolonged continuous local pressure over the area of lymph extravasation.



## **Vacuum-assisted closure for cutaneous gastrointestinal fistula management.**

**Alvarez AA, Maxwell GL, Rodriguez GC.**

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**BACKGROUND:** Cutaneous gastrointestinal (GI) fistulas are a challenging complication in the oncologic patient population. The fistulous effluent is difficult to manage and adversely alters quality of life. Nonsurgical management of enteric fistulas is successful in 30% of cases, requiring at least 4 to 6 weeks. Recently a new technology has been developed to expedite wound healing. The Vacuum-Assisted Closure (VAC) method is a subatmospheric pressure technique that has been demonstrated in laboratory and clinical studies to significantly improve wound healing. Here we report its use in the successful medical management of a cutaneous GI fistula. **CASE:** A 63-year-old woman with advanced ovarian cancer developed an extensive complex cutaneous GI fistula in an open healing wound. She was treated with total parental nutrition and the VAC device, which resulted in complete closure of the fistula. **CONCLUSION:** We propose that the VAC device may be a useful adjunct for the medical management of cutaneous GI fistulas. Copyright 2001 Academic Press.

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- [Postgrad Med J. 2002 Nov;78\(925\):699; author reply 699.](#)

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**Vacuum assisted closure system in the management of**

## **enterocutaneous fistulae.**

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**BACKGROUND:** A very important yet often troublesome element in the conservative management of enterocutaneous fistulae is the protection of the surrounding skin from contact with the effluent. This report describes the successful use of a vacuum assisted closure (VAC) system in dealing with this problem. **METHODS:** The results of using the VAC system were studied in three patients with moderate or high volume output enterocutaneous fistulae where conventional treatment had failed to prevent skin excoriation. **RESULTS:** The VAC system was found to be highly effective in controlling fistula effluent and in promoting healing of excoriated skin in all three patients. Complete healing of the fistula was also achieved in two of the three patients. **CONCLUSION:** The VAC system can be an effective and economically viable method of containing fistula effluent and protecting the skin of patients with enterocutaneous fistulae. Contrary to conventional thought, the VAC system may also actually promote healing of the fistula.

Br J Plast Surg. 2000 Sep;53(6):484-7.

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## **The use of subatmospheric pressure dressing therapy to close lymphocutaneous fistulas of the groin.**

**Greer SE, Adelman M, Kasabian A, Galiano RD, Scott R, Longaker MT.**

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Groin lymphorrhoea is an uncommon but serious complication of vascular and cardiac surgery as well as interventional procedures that cannulate the femoral vessels. Treatment options are somewhat controversial. For lymphocutaneous fistulas, a commonly used current modality is early surgical ligation with the assistance of blue-dye staining of the lymphatic anatomy. The purpose of this case series is to give the first description of a new, less invasive, approach using subatmospheric pressure dressing therapy for the treatment of the challenging problem of lymphocutaneous fistulas of the groin.

Tidsskr Nor Laegeforen. 1996 Jun 20;116(16):1886-8.

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## **[Lymphatic complications after lower limb vascular surgery]**

[Article in Norwegian]

**Haaverstad R, Urnes O, Dahl T, Myhre HO.**

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A series of five patients with lymph fistula and two with lymphocele is described. Lymphatic complications in the groin and thigh following infrainguinal arterial surgery may increase the risk of wound infection and prolong the stay in hospital. During operation for lymph fistula and lymphocele, precise identification of the site of lymph leakage during exploration of the wound is mandatory. This can be obtained by intradermal injection of Patent blue 2.5% medially and laterally on the dorsum of the foot approximately one hour before operation. Operation for lymph fistula should be performed as soon as the diagnosis has been verified, especially if a prosthetic graft has been used. A lymphocele should be treated conservatively unless the patient is suffering from localized pain or ischemia of the skin caused by pressure of the underlying swelling.