

CLINICAL CASE REPORT

Craig Hornbarger, MD
Skyridge Medical Center, Lone Tree, CO

Bard* AlloMax* Surgical Graft for Abdominal Wall Reconstruction after Tumor Resection

Presentation and History

The patient is a 34-year-old African-American female whose past surgical history includes an open cholecystectomy for acute and subacute cholecystitis. This was complicated by the development of an adhesive small bowel obstruction requiring laparotomy. Approximately two and a half years later, the patient noticed a bulge in the lateral aspect of her right upper quadrant. She subsequently underwent wide excision of an abdominal wall mass and abdominal wall reconstruction with the implantation of mesh. The mass pathology revealed a desmoid tumor with a close surgical margin. After conferring with oncology, surgery was scheduled to re-excise more widely through the subcostal incision, remove the old mesh, make sure there were clean margins, and place a larger Bard* AlloMax* Surgical Graft.

Surgical Intervention

The patient was prepped and draped in the usual sterile fashion. Using a 10-blade scalpel, her previous incision was re-incised in the right upper quadrant through the skin and dermis. Bovie electrocautery dissection continued down through the subcutaneous tissue and down to the level of the abdominal wall. Because of the scarring process, it was impossible to differentiate between the mesh that had been placed previously and the abdominal wall. A wide excision was made through this area with a Bovie electrocautery instrument down to the ribs and to the peritoneum. A sample was forwarded to pathology.



Bard* AlloMax* Surgical Graft



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The area was measured, and a 10cm x 15cm Bard* AlloMax* Surgical Graft was soaked in saline for three minutes, cut into an oval shape, and placed to reconstruct part of her abdominal wall. A bridge repair was utilized as the fascia inclusive of the tumor had to be excised leaving a large defect. The graft was sewn into position with interrupted U stitches of 0-PROLENE* suture to surrounding fascia and muscle. Upon completion, the subcutaneous tissue was closed in two layers with interrupted 2-0 VICRYL* suture to close the dead space. Her subcutaneous tissues were injected with 20mL of Marcaine* and her skin was closed with a running 4-0 MONOCRYL* subcuticular stitch. DERMABOND* and occlusive dressing were applied. She was extubated and brought to the postanesthetic recovery room. She tolerated the procedure well.

Results

On a three week postoperative visit, the patient had no complaints other than some swelling in the area. An examination revealed that her incision was healing nicely, and that she appeared to have developed a seroma. Under sterile conditions and local anesthesia, approximately 160mL of serosanguinous fluid was aspirated with a good result. The patient was seen postoperatively at 6 weeks and 10 months with no recurrence of the seroma or hernia and with an excellent cosmetic and functional result.

Conclusion

In this patient with a desmoid tumor, Bard* AlloMax* provided excellent abdominal wall reconstruction without resulting in an overly exuberant inflammatory response. This very likely contributed to the successful surgical outcome.

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100 Crossings Boulevard • Warwick, RI 02886
1.800.556.6275 • www.davol.com