LETTER TO THE EDITOR

Treatment of catamenial pneumothorax with absorbable mesh, pleurectomy and pleural abrasion

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Received 7 August 2012; accepted 7 September 2012

Keywords: Catamenial pneumothorax • Mesh • Pleurodesis • Thoracic

We read with interest the paper by Ikeda et al. [1] regarding the treatment of catamenial pneumothoraces. We agree with the authors that the pathology of true catamenial pneumothorax is not clear. However, in most cases, diaphragmatic fenestrations play a role. On the left, the fenestrations are frequently plugged by the omentum. On the right, however, the liver prevents such plugging, which accounts for the right-sided prevalence of the catamenial pneumothorax.

We too have used an absorbable mesh in the treatment of catamenial pneumothoraces for a number of years with good results; however, our practice differs from the one described by the authors. We have satisfactory results fixing the patch to the diaphragm without applying a patch to the lung tissue [2]. Our ability to inspect the diaphragm has improved, and our technique has evolved with the introduction of thoracoscopy. Whereas previously, via a muscle-sparing thoracotomy, we would have sutured a polygalactin mesh over the defects in the diaphragmatic surface, we now use an endoscopic tacker (The ProTack™ 5-mm Fixation Device, Covidien, UK) to fix the patch at thoracoscopy. This can be added to the standard pleurectomy and abrasion technique using three thoracoscopic ports. We would recommend that any surgeon operating on a female patient for pneumothorax should examine the diaphragm and treat any defects appropriately.

REFERENCES


LETTER TO THE EDITOR RESPONSE

Reply to Rychlik and McManus

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Received 3 September 2012; accepted 7 September 2012

Keywords: Catamenial pneumothorax • Recurrence • Absorbable mesh • Pleurodesis

We thank Dr Rychlik and Dr McManus for their attention to our work and for giving us this opportunity to participate in this worthwhile discussion.

We have previously reported a method involving absorbable mesh for the prevention of catamenial pneumothorax (CPX) [1]. The letter by Rychlik and McManus questions whether