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Surgical management of bronchopleural fistula using a greater pectoral muscle flap in empyema due to aspergillus infection

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Intra-thoracic defects continue to be one of the most challenging problems faced by reconstructive surgeons, particularly in the presence of bronchopleural fistulas. We describe the use of a greater pectoral muscle flap to fill an intrathoracic defect and close a pleural window. A 67-year-old male patient was admitted for surgical treatment of an aspergilloma with right pneumothorax. During the surgery, the area of the air leak at the aspergilloma was covered with a polyglycolic acid sheet and fibrin tissue adhesive. Due to the extreme hardness of the tissue, partial resection of the part of the lung containing the aspergilloma was impossible. An abscess had also accumulated in the right thoracic cavity around the aspergilloma. Reaching a diagnosis of empyema due to aspergillus infection, fenestration was performed 5 weeks after the first operation. Gauze inserted into the abscess cavity through the pleural window made by fenestration was changed daily or every several days. However, a bronchopleural fistula occurred several weeks after the second surgery. The infection was finally controlled nine months after the second surgery, following which a third operation was performed. A greater pectoral muscle flap was created and inserted into the space of the empyema. The intrathoracic defect and pleural window were perfectly covered with the flap and skin. To date, ten months after the third surgery, the empyema and bronchopleural fistula have not relapsed and the patient does not experience any discomfort.

Biography

Hiromitsu Domen graduated from Hokkaido University School of Medicine at the age of 28. He is a specialist in thoracic and digestive tract surgery in Japan. He has published more than 15 papers in reputed journals.