Prevention of adhesion formation in a laparoscopic mouse model should combine local treatment with peritoneal cavity conditioning†

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BACKGROUND: Adhesion formation results from a series of local events at the trauma site. This process can be enhanced by factors derived from the peritoneal cavity such as mesothelial cell hypoxia (pneumoperitoneum with pure CO2), reactive oxygen species (pneumoperitoneum with more than 4% oxygen), desiccation and mesothelial trauma produced through manipulation. Adhesion prevention, therefore, should combine local treatment while minimizing adverse peritoneal factors through conditioning of the pneumoperitoneum.

METHODS: In a laparoscopic mouse model, adhesion induction comprised a mechanical lesion together with a humidified pneumoperitoneum for 60 min with pure CO2 at 37°C. Adhesion prevention consisted of a combination of treatments known to reduce adhesions, i.e. pneumoperitoneum with CO2 with the addition of 3–4% O2, reduction of body temperature (BT) to 32°C and application of antiadhesion products such as anti-inflammatory drugs (dexamethasone, nimesulide), calcium-channel blockers (diltiazem), surfactants (phospholipids), barriers (Hyalobarrier gel), reactive oxygen species scavengers (superoxide dismutase and ascorbic acid) and recombinant plasminogen activator.

RESULTS: The addition of 3% O₂ to the pneumoperitoneum or a lower BT decreased adhesions by 32% or 48%, respectively (P < 0.05, Wilcoxon), but were without additional effects when combined. In addition, if dexamethasone or Hyalobarrier® gel were administrated, the total reduction was 76% (P = 0.04) or 85% (P < 0.02), respectively.

CONCLUSIONS: Combining pneumoperitoneum conditioning together with dexamethasone or a barrier resulted in significant adhesion reduction in a laparoscopic mouse model.

Key words: post-operative adhesions / laparoscopy / humidified gas / pneumoperitoneum conditioning / mouse model

Introduction

Adhesion formation consists of a series of local events at the trauma site. Peritoneal injury caused by surgery, infection or irritation initiates an inflammatory reaction with fibrin exudate and deposition into which white blood cells, macrophages, fibroblasts and mesothelial cells migrate, proliferate and/or differentiate. A key factor in adhesion prevention is fibrinolysis, which is regulated by the plasminogen system. The inactive proenzyme plasminogen is converted into plasmin by tissue-type plasminogen activator (tPA) and/or urokinase-type plasminogen activator. The fibrin matrix serves as a scaffold for fibroblasts and capillary ingrowth and for extracellular matrix (ECM) deposition. During normal healing, the fibrin matrix is rapidly removed and the ECM will be degraded by metalloproteinases (MMPs). On the contrary, if the fibrin matrix persists too long, or when the ECM degradation is inhibited, peritoneal adhesions will be formed (Holmdahl, 1997; diZerega, 2000).

These local events are modulated by factors derived from the peritoneal cavity such as mesothelial cell hypoxia (pneumoperitoneum with pure CO2), reactive oxygen species (pneumoperitoneum with more than 4% oxygen), desiccation and mesothelial trauma, which have been recognized as cofactors in adhesion formation. Today, the adhesiogenic factors recognized acting upon the entire peritoneal cavity are mesothelial hypoxia (Molinas et al., 2001), mesothelial

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Clinical and therapeutic strategies in prevention of adhesion formation. The action of flotation agents or barriers such as SprayGel, Intercoatates traumatized areas for at least 5 days. This has been translated as hypothermia attenuates hypoxia-, hyperoxia- or desiccation-enhanced
hypoxia (Elkelani et al., 2004) and reactive oxygen species (ROS) (Binda et al., 2006) and mesothelial mechanical trauma (Schonman et al., in press). Indeed, adhesions increase with the duration of pneumoperitonemum and the insufflation pressure, and this effect is prevented by the addition of 3% oxygen but not by using helium instead of CO₂ for the pneumoperitoneum (Molinas and Koninckx, 2000; Molinas et al., 2001). Moreover, with the addition of more than 3–4% oxygen to CO₂, the pneumoperitoneum is deleterious probably due to ROS production (Elkelani et al., 2004). To understand the importance of oxygen concentration in the pneumoperitoneum, we should remember that the normal partial pressure of oxygen (pO₂) of mesothelial cells is between 5 and 40 mmHg (Guyton and Hall, 2000), which is similar to the addition of 3–4% oxygen at a pressure of 770 mmHg (atmospheric pressure of 760 mmHg plus insufflation pressure of 10 mmHg). The addition of 12% oxygen at 770 mmHg thus results in a pO₂ of 92 mm Hg, which is much higher than the normal intracellular pO₂ and, therefore, hyperoxic. In addition, desiccation is clearly adhesionogenic and this can be prevented by using humidified gas (Binda et al., 2006; Peng et al., 2008). Manipulation of omentum and bowels in the upper abdomen also increase adhesion formation at the trauma site in the lower abdomen (Schonman et al., in press), confirming unequivocally that factors derived from the peritoneal cavity modulate adhesion formation at the trauma site. Another argument to conclude that CO₂ pneumoperitoneum and desiccation constitute an injury to the mesothelial cells is derived from scanning electron microscopy describing bulging up of the mesothelial cells and exposure of the extracellular matrix (Volz et al., 1999). Not surprisingly, hypothermia attenuates hypoxia-, hyperoxia- or desiccation-enhanced adhesion formation (Binda et al., 2004, 2006).

Adhesion prevention can be achieved by using barriers that separates traumatized areas for at least 5 days. This has been translated clinically using flotation agents or barriers such as SprayGel, Intercoat or Hyalobarrier® gel, all achieving an adhesion reduction of 40–50%. Besides this, many other products have been described in a great variety of animal models to prevent adhesion formation. In order to obtain comprehensive comparative data, these products have been evaluated in one model, i.e. our laparoscopic mouse model comprising 60 min of pure CO₂ pneumoperitoneum. In brief, our results confirmed that barriers such as SprayGel and Hyalobarrier® gel were effective in reducing adhesion, by 58% and 90%, respectively and a surfactant such as phospholipids was also effective giving a 35% reduction (Binda et al., 2007a). They also confirmed that adhesions were reduced, by around 20% and 30%, when using ROS scavengers, i.e. ascorbic acid and superoxide dismutase (SOD), respectively, by 32% when using dexamethasone, by 36% when using a calcium-channel blocker as diltiazem, a calcium-channel blocker, reduced adhesion formation in our laparoscopic model (Binda et al., 2007b). The suggested cause of this effect involves mechanisms such as interference with the inflammatory response (Szabo et al., 1997), protection against the toxic effect of the ischemic–reperfusion cell injury (Wang et al., 2002) or activation of cellular processes (Elmslie, 2004). After having identified different mechanisms affecting adhesion formation, we evaluate which therapies have additive effects, i.e. which therapies could be used simultaneously to minimize adhesion formation. Therefore, besides preventing tissue trauma and desiccation, we first investigated whether the addition of 3–4% oxygen and slight cooling, factors that could be used routinely during surgery, have additive effects. Subsequently, we wanted to know which other factors could advantageously be used in a model without desiccation and hypoxia.

Materials and Methods

The laparoscopic mouse model for adhesion formation

Each aspect of the experimental setup, i.e. strain of mice used (Molinas et al., 2005), anaesthesia and ventilation (Molinas et al., 2004), laparoscopic surgery for induction of adhesions, duration and pressure of the pneumoperitoneum, type of gas used (Molinas et al., 2001; Elkelani et al., 2004), humidification and temperature (Binda et al., 2004, 2006), has been described in detail previously.

In these experiments, we used a laparoscopic model with Balb/c mice as a reference, a bipolar lesion and 60 min of pure CO₂ pneumoperitoneum. Insufflation gas and body temperatures (BTs) were strictly kept at 37°C using a heated chamber (Binda et al., 2004), and peritoneal trauma by manipulation of peritoneal organs or desiccation was kept to a minimum by the experience of the investigator and full humidification, respectively.

Animals

In this study, one hundred twelve 9- to 10-week-old female BALB/c mice weighing 20 g were used. Mice were kept under standard laboratory conditions and were fed with a standard laboratory diet with free access to food and water at anytime. The study was approved by the Institutional Review Animal Care Committee.

Anaesthesia and ventilation

Mice were anaesthetized with i.p. 0.08 mg/g pentobarbital, intubated with a 20-gauge catheter and mechanically ventilated (Mouse Ventilator MiniVent, Type B45, Hugo Sachs Elektronik-Harvard Apparatus GmbH, March-Hugstetten, Germany). The ventilation was done at a tidal volume of 250 μl at 160 strokes/min as this condition prevents hypercarbia/acidosis enhanced by the pneumoperitoneum (Molinas et al., 2004) and humidified room air was used to prevent cooling (Binda et al., 2004).

Laparoscopic surgery

A midline incision was performed caudal to the xyphoides, a 2-mm endoscope with a 3.3-mm external sheath for insufflation (Karl Storz,
Tuttlingen, Germany) was introduced into the abdominal cavity and the incision was closed gas tight around the endoscope in order to avoid leakage. Pneumoperitoneum was created with pure CO2 or CO2 with the addition of 3% oxygen at 15 mmHg insufflation pressure using the Thermodiaphlan Plus (Karl Storz) and a water valve to dampen pressure changes. The gas was humidified (Storz Humidifier 204320 33, Karl Storz) and the whole set up was kept in a chamber at 37°C in order to obtain the insufflation gas at 37°C and with 100% relative humidity. We used, as described previously, a controlled flow of the insufflation gas through the abdominal cavity of 23 ml/min using a 26-gauge needle, in order to ascertain a continuously pure CO2 or 3% O2 environment by removing constantly any oxygen that might have diffused from the capillaries.

Induction of intraperitoneal adhesions
Pneumoperitoneum-enhanced adhesion formation was induced by maintaining the pneumoperitoneum for 60 min and by performing standardized 10 × 1.6 mm lesions in the antimesenteric border of both right and left uterine horns and pelvic sidewalls with bipolar coagulation (BICAP™, bipolar hemostasis probe, BP-5200A, 5 Fr, 200 cm; IMMED Benelux, Linkebeek, Belgium) at 20 W (Autocon 200, Karl Storz, standard coagulation mode).

Control of temperature
Since anaesthesia and ventilation can influence BT, the timing was strictly controlled. The time of anaesthesia injection was considered time zero (T0). The animal preparation and ventilation started after exactly 10 min (T10). The pneumoperitoneum started at 20 min (T20) and was maintained for 60 min till T30. BTs were strictly controlled at 37°C using a heated chamber. In some groups, cooling was induced and BT was reduced to 32°C as explained previously (Binda et al., 2004).

Scoring of adhesions
Adhesions were qualitatively and quantitatively scored. Scoring was done blindly (the investigator was not informed of the group being evaluated) after 7 days during laparotomy using a stereomicroscope (Wild Heerbrugg M7A, Gais, Switzerland) and it was standardized for all groups. The quantitative scoring system assessed the proportion of the lesions covered by adhesions using the following formula: adhesion (%) = (sum of the length of the individual attachments/length of the lesion) × 100. The qualitative scoring system assessed: extent (0: no adhesions; 1: 1–25%; 2: 26–50%; 3: 51–75%; 4: 76–100% of the injured surface involved, respectively), type (0: no adhesions; 1: filmy; 2: dense; 3: capillaries present), tenacity (0: no adhesions; 1: easily fall apart; 2: require traction; 3: require sharp dissection) and total (extent + type + tenacity). The results are presented as the average of the adhesions formed at the four individual sites (right and left visceral and parietal peritoneum), which were individually scored.

Products used
Anti-inflammatory drugs. Dexamethasone (Aacidexam 5 mg for injection, Organon, Bruxelles, Belgium) was prepared the day of the experiment as indicated by manufacturer and diluted to 80 μg/ml in saline (NaCl 0.9%) and kept at 4°C. Nimesulide (Sigma, Bornem, Belgium) was dissolved in DMSO (30 mg/ml) and kept at −20°C till used. Ascorbic acid (AA) (Sigma) was dissolved to 20 mg/ml in saline before using.

Calcium-channel blocker. Diltiazem hydrochloridum (Tildiem i.v. 25 mg, Sanoﬁ-Synthelabo S.A.N.V., Bruxelles, Belgium) was prepared on the day of the experiment as indicated by manufacturer, diluted to 0.2 mg/ml in saline and kept at 4°C.

Barriers. Hyalobarrier® gel is a sterile, transparent and highly viscous gel, obtained by condensation of hyaluronic acid through an auto-cross-linking process and is indicated for laparoscopic and hysteroscopic or open surgical procedures. It was kindly provided by Fidia Advanced Biopolymers SRL (Abano Terme, Padova, Italy).

Surfactant. Phospholipids solution (9%), kindly given by Dr Marc Jansen (Department of Surgery, University Clinic, RWTH Aachen, Germany), was diluted to 3% in saline before use.

Recombinant human PA. Reteplase (Rapilysin® 10 U, Roche) was prepared as indicated by manufacturer and diluted to 2 μg/ml and kept at −20°C.

All the dosages used in these experiments were shown to be effective to prevent adhesions in our model as published (Binda et al., 2007a, b, 2009).

Experimental design
As a comparison, adhesions caused by a mechanical lesion enhanced by 60 min CO2 pneumoperitoneum strictly at 37°C but without desiccation was used. Addition of 3–4% of oxygen to the pneumoperitoneum, cooling and all products had been demonstrated to be effective in reducing adhesions previously (Molinas et al., 2001; Binda et al., 2004, 2006, 2007a, b, 2009; Eikelani et al., 2004).

Experiment I was designed to evaluate whether a lower BT and addition of 3% oxygen to the pneumoperitoneum have additive effects in reducing adhesion formation with the hypothesis that at lower temperature cells are more resistant to the deleterious effects of hypoxia and that the effects of both treatments thus should not be additive. The experiment used a factorial design, i.e. mice without (37°C) and with (32°C) cooling and mice with (pure CO2 pneumoperitoneum) and without (CO2+3% of oxygen) hypoxia. The four groups thus were: pure CO2 pneumoperitoneum and mice BT at 37°C, pure CO2 and mice at 32°C, CO2 pneumoperitoneum + 3% O2 and mice at 37°C and CO2+3% O2 and mice at 32°C (Table I). In order to permit comparison with the other groups, all mice received four doses of saline. We indeed previously demonstrated that administration of saline does not affect adhesion formation in comparison with control mice (Binda et al., 2009). Considering full humidification, the addition of 3% of oxygen and slight cooling (32°C BT) as optimal gas conditioning, we evaluated, in addition to this, whether dexamethasone, or a calcium-channel blocker (diltiazem) or a surfactant (phospholipids), could further reduce adhesion formation.

Since dexamethasone has a long half-life, i.e. 36–72 h (Nilson, 1994; Brunton et al., 2006), treated mice received two i.p. doses of 0.5 ml immediately after performing the lesion and the day after the surgery. Since diltiazem has a shorter half-life (1.5–7 h) (Eisenberg et al., 2004), treated mice received four i.p. doses of 0.5 ml (immediately after performing the lesion, 6 h after that, 24 h after surgery and 6 h thereafter). For phospholipids-treated mice, 0.5 ml of phospholipids 3% was i.p. injected under laparoscopic view after performing the lesions (seven groups, eight mice per group).

Experiment II was designed to evaluate whether, in addition to optimal pneumoperitoneum conditioning, adhesions could be further reduced by a COX-2 selective NSAIDs (nimesulide), by a barrier (Hyalobarrier® gel),...
Table I  Adhesion prevention in a laparoscopic mouse model

<table>
<thead>
<tr>
<th>Exp.</th>
<th>Treatments</th>
<th>BT (°C)</th>
<th>Products</th>
<th># Doses</th>
<th>Conc.</th>
<th>Scoring (mean ± SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gas used for the PP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quantitative</td>
</tr>
<tr>
<td>I</td>
<td>Pure CO₂</td>
<td>37</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>34.4 ± 3.3</td>
</tr>
<tr>
<td></td>
<td>Pure CO₂</td>
<td>32</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>18.7 ± 3.4*</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>37</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>23.4 ± 2.6*</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>19.7 ± 1.8*</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Dexamethasone</td>
<td>2</td>
<td>40 µg</td>
<td>8.6 ± 3.3b</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Diltiazem</td>
<td>4</td>
<td>100 µg</td>
<td>14.2 ± 2.8</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Phospholipids</td>
<td>1</td>
<td>3%</td>
<td>14.3 ± 1.7</td>
</tr>
<tr>
<td>II</td>
<td>Pure CO₂</td>
<td>37</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>33.8 ± 2.3</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Saline</td>
<td>4</td>
<td>—</td>
<td>17.4 ± 2.5*</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Nimedesulide</td>
<td>4</td>
<td>100 µg</td>
<td>19.6 ± 3.3</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>SOD</td>
<td>1</td>
<td>300 U</td>
<td>21.3 ± 2.1</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>AA</td>
<td>1</td>
<td>2 mg</td>
<td>29.5 ± 1.6b</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Hyalobarrier® gel</td>
<td>1</td>
<td>—</td>
<td>5.0 ± 1.1b</td>
</tr>
<tr>
<td></td>
<td>CO₂ + 3%O₂</td>
<td>32</td>
<td>Retelplase</td>
<td>4</td>
<td>1 µg</td>
<td>19.7 ± 2.3</td>
</tr>
</tbody>
</table>

Quantitative (proportions) and qualitative (extent, type, tenacity and total) scoring systems are indicated. Laparoscopy was performed using humidified pure CO₂ or CO₂ with the addition of 3–4% O₂ to the pneumoperitoneum (PP) and BT as kept at 32 or 37 °C. Different products were applied. The volumes administrated were 500 µl for all the groups, except for SOD and AA that 100 µl was used and Hyalobarrier® gel that around 1 ml was applied. Statistic: Wilcoxon test: P < 0.05.

*Comparison with control pure CO₂ pneumoperitoneum, 37 °C BT.

Discussion

These experiments confirmed that hypothermia (32 °C) and the addition of 3% oxygen to the pneumoperitoneum reduce adhesions in comparison with pure CO₂ at 37 °C by 48% and 32%, respectively (Binda et al., 2004). Using both treatments together did not have manifested additional effects that are consistent with the hypotheses that
the addition of 3% of oxygen prevents the mesothelial hypoxic trauma caused by pure CO₂, whereas at a lower temperature cells are more resistant to hypoxia. Since our results do not permit the detection of minor differences, we cannot exclude that cooling and adding 3% oxygen might have slight additional effects. This, anyway, would not contradict the hypothesis of a common pathway. Conditioning of pneumoperitoneum, thus, should comprise today perfect humidification, the addition of a few percent of oxygen and slight cooling instead of heating as has been suggested. Considering the hypothesis that hypoxia of the superficial layer is a driving mechanism for adhesions, then delivering oxygen to the cells in order to achieve some 30–40 mmHg is crucial. Increasing the ppO₂ in the blood by ventilation will help, however, adding the oxygen directly to the pneumoperitoneum is obviously easier and more effective. Cooling together with prevention of desiccation can, however, not be achieved that easily, since it will require cooling of the peritoneal cavity by external means. Indeed, if the insufflated gas is cooled, the absolute humidity will drop, and after the gas is heated in the peritoneal cavity to the BT, desiccation is inevitable and will occur.

Many products have been described to be effective in decreasing adhesion formation both in the human and in animal models, which unfortunately have not been that strictly characterized and the experimental conditions vary widely. We, therefore, have evaluated previously the effect of a large number of these products in our well-defined laparoscopic mouse model with 60 min of CO₂ pneumoperitoneum at 37°C BT. Since the addition of 3% of oxygen and slight cooling already decrease adhesion formation by some 50% in the laparoscopic mouse model, we now wanted to investigate which products are still effective in this model. Of all products investigated for further decreasing adhesion formation in addition to peritoneum conditioning, the effect of dexamethasone is remarkable. Dexamethasone reduces adhesions by 32% when pure CO₂ is used for the pneumoperitoneum (Binda et al., 2007b), but resulted in a total decrease in adhesion formation of 76% in comparison with pure CO₂ at 37°C when it is combined with the peritoneum conditioning. Since nimesulide had no additive effect to adding oxygen and cooling, we suggest that the effectivity of dexamethasone is mediated through mechanisms other than reducing inflammation. Indeed, glucocorticoids can inhibit fibroblast proliferation while having an immunosuppressive effect affecting production and release of cytokines (Brunton et al., 2006). Moreover, since these pathways would be different to those involved in hypothermia and the addition of 3% oxygen, the additive effect is plausible.

With peritoneum conditioning, the calcium-channel blocker diltiazem and phospholipids further decreased adhesion formation.
by some 20%, resulting in a total reduction of some 60%. This additional effectiveness, however, failed to reach statistical significance, which is not surprising since much larger groups would be required to demonstrate the effect unequivocally. Moreover, it would be interesting to investigate the additional effect after 3% oxygen, slight cooling and dexamethasone administration, since this would suggest a different pathway. Indeed, phospholipids are considered to lubricate the peritoneum, whereas diltiazem is considered to affect the inflammatory response while protecting cells against the toxic effect of the ischemia—reperfusion injury. Since the demonstration of the effect in a model with already 75% adhesion reduction requires such large groups, we decided to postpone these experiments until more information would have been gathered.

Hyalobarrier® gel clearly decreased adhesion formation in addition to 3% oxygen and cooling, resulting in some 85% adhesion reduction in total, thus confirming the effect of Hyalobarrier® in the CO₂ pneumoperitoneum model at 37°C (Binda et al., 2007a). This additional effect is not surprising since the mechanism of action of Hyalobarrier® is considered to be a local barrier, whereas 3% of oxygen and cooling are considered to act upon the entire peritoneal cavity. At present, we can only speculate based on their mechanisms of action that barriers will decrease adhesion formation by more than 90% when given in the 3% oxygen and cooling model along with dexamethasone treatment.

Superoxide dismutase, an ROS scavenger, did not show an additional effect to the treatments, 3% oxygen addition and cooling. Since a 38% reduction was achieved in the CO₂ model at 37°C BT, we postulate that this is due to the decrease in ROS scavengers in this model (Binda et al., 2007b). To explain the increase in adhesions by AA in the 3% oxygen and cooling model, and the borderline effect in the pure CO₂ model at 37°C, we have to postulate some irritation by the acidic AA. Although Reteplase has shown a 40% effective in the pure CO₂ 37°C model (Binda et al., 2009), it failed to demonstrate additional effect in the 3% oxygen—cooling model.

Adhesion prevention by conditioning the pneumoperitoneum during surgery, e.g. adding 3% of oxygen and slight cooling without desiccation, together with the administration of dexamethasone and a barrier, after surgery is theoretically and clinically attractive. Theoretically, the mechanisms of adhesion prevention are believed to be different. Adding 3% oxygen to the pneumoperitoneum and cooling prevent mesothelial cell hypoxia with induction of angiogenic factors and decrease in ROS. Both of these, as well as desiccation, have an effect upon the entire peritoneal cavity. The mechanisms of adhesion prevention by dexamethasone is less clear but given the ineffectivity of COX-2 inhibitors, it is probably not through the reduction of inflammation, and a barrier has a mechanical effect by acting locally. Clinically, this combination therapy is attractive since it combines pneumoperitoneum conditioning during surgery, with drug treatment and a barrier after surgery, with a speculated overall effect of more than 90% adhesion reduction. Obviously, this will have to be validated in clinical trials.

Although the side effects of the low temperature are well known (Insler and Sessler, 2006), induced hypothermia is one of the most promising neuroprotective therapies (Hemmen and Lyden, 2007). Application of therapeutic hypothermia after cardiac arrest could help to improve the neurological recovery (Bernard et al., 2002; Hypothermia after Cardiac Arrest Study Group, 2002; Holzer et al., 2005). Moreover, the hypothermia—cerebroprotection effect can be improved by additional pharmacotherapy in patients subjected to ischemia–reperfusion (Schmid-Elsaesser et al., 1999). In addition, combined therapies with mild hypothermia (33°C) were efficient for neuroprotection during cerebral ischemia in cerebrovascular surgery (Zausinger et al., 2003). These examples are different from our model; however, they both have the common pathway of the ischemia–reperfusion and the protection of its toxic effects. Since hypothermia was induced for longer time and in the whole body, those would be extreme examples suggesting that hypothermia can also be used locally in humans. A recent article of Ozgonul et al. (2007) supports our theory of using low temperature locally. In this study, hypothermic CO₂ (21°C) used for pneumoperitoneum was compared with isothermic gas (37°C) during laparoscopic cholecystectomy in a prospective randomized study. Measurements were done before insufflation, at 30 min of pneumoperitoneum and 30 min after desufflation. No significant difference was observed in core BT and blood arterial pH, arterial carbon dioxide pressure, arterial oxygen pressure and bicarbonate values, although the mean skin BT was significantly higher in the isothermic group than the hypothermic group. We indeed should apply hypothermia carefully in women. This will be the next experiment since by preliminary data demonstrate that when cooling the abdominal cavity, the cooling is only superficial. Our hypothesis that superficial mesothelial cooling is sufficient to prevent the hypoxic effect.

In summary, we demonstrated that conditioning the pneumoperitoneum by cooling and/or adding 3% oxygen, some 50% reduction of adhesion formation can be achieved. Adhesion formation can be further reduced to 76% by adding dexamethasone or 85% by applying Hyalobarrier® gel after surgery. With these data, we suggest that adhesion formation prevention should become multifactorial combining pneumoperitoneum conditioning, medical treatment and mechanical barriers. Whereas for now, dexamethasone has been identified as effective, the exact place of calcium channel blockers or phospholipids in this combination model remains unclear.

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Combination of therapies to prevent adhesion formation


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