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No evidence of Permacol rejection presented by Wotton and Akoh

Neil James Smart

Neil James Smart, Department of General Surgery, Royal Devon & Exeter Hospital, Barrack Road, Exeter, EX2 5DW, United Kingdom
Author contributions: Smart NJ wrote this letter.
Correspondence to: Neil James Smart, PhD, MBBS (Hons), MRCSEd, Department of General Surgery, Royal Devon & Exeter Hospital, Barrack Road, Exeter, EX2 5DW, United Kingdom. drneilsmart@hotmail.com
Telephone: +44-1392-411611
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Abstract

Wotton and Akoh in their previously reported case in this journal postulate that Permacol rejected. This letter provides a detailed critique of that claim and provides an alternative explanation for the histological data provided by the authors. It is also argued that Wotton and Akoh have misrepresented one of the papers in the discussion in their article and a clarification of that referenced paper is given.

Key words: Porcine dermal collagen implant (Permacol); Renal Transplant; Rejection

Peer reviewer: Antonio Basoli, Professor, General Surgery "Paride Stefanini", Università di Roma - Sapienza, Viale del Policlinico 155, Roma 00161, Italy

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TO THE EDITOR

Wotton and Akoh[1] have misrepresented one of the cases published in a case series I co-authored[2] on the use of Permacol in abdominal wall closure in paediatric renal transplantation in a specious attempt to justify their conclusions.

It is true that one out of five children did suffer a dehiscence of their abdominal wound following the use of Permacol to close the abdominal wall in size mismatched renal transplants. In the particular case discussed, the 9-year-old male had steroid refractory nephrotic syndrome and underwent a bilateral nephrectomy for persistently low albumin levels. That the wound did not heal was much more likely due to chronic steroid use and hypoalbuminaemia than any reaction to the Permacol. It is misleading to use this case as supporting evidence for Wotton and Akoh's claims that Permacol may induce foreign body reaction or rejection.

I see no reliable evidence presented in this case report that Permacol was "rejected". Firstly, we are not told which suture material was used to suture the Permacol in place, but we are informed that the "histology revealed features of acute and chronic inflammation superficially and granulomatous inflammation in the deep layer consistent with a "stitch granuloma". Is it not possible that this "stitch granuloma" could well have been due to the suture material itself rather than Permacol? Secondly, the use of the term "rejection" implies a specific immunopathological entity. "Features of acute and chronic inflammation" is so non-specific that it could be due to any number of factors, but I hypothesize that it was most likely due to the contaminated field. No detailed pathological or immunological evidence (such as characterisation of lymphocytes present, immunofluorescence, immunostaining or electron microscopy) is presented to substantiate the claim of rejection of the Permacol. Since this is alleged to be the first report on rejection of Permacol in humans, the evidence needs to be

more substantial than that presented before the claim can be given credence.

REFERENCES

1 **Wotton FT**, Akoh JA. Rejection of Permacol mesh used in abdominal wall repair: a case report. *World J Gastroenterol* 2009; **15**: 4331-4333

2 **Pentlow A**, Smart NJ, Richards SK, Inward CD, Morgan JD. The use of porcine dermal collagen implants in assisting abdominal wall closure of pediatric renal transplant recipients with donor size discrepancy. *Pediatr Transplant* 2008; **12**: 20-23

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