INTRODUCTION

Gastro-esophageal reflux is a common disease that accounts for approximately 75 percent of esophageal pathology. Despite its prevalence, it is one of the most challenging diagnostic and therapeutic problems in benign esophageal disease, chiefly because there is no universally accepted definition of the disease ***(Deviére, 2002)***.

The main cause of increased esophageal exposure to gastric juice in patients with gastro-esophageal reflux disease is a mechanically incompetent lower esophageal sphincter. This accounts for about 60 to 70 percent of gastro-esophageal reflux disease, the identification of this cause is important, since it is the one that antireflux surgery is designed to correct ***(Ludwig, 2003)***.

The normal subjects have reflux episodes both in the fasting state and especially postprandially. However, these episodes are short-lived due to the efficient clearing mechanism of the esophagus. This contrasts with the situation in reflux disease, where, the reflux episodes are more frequent and last longer resulting in prolonged contact time between refluxed gastric contents and esophageal epithelium leading to direct chemical damage and subsequent esophagitis, Barrett's metaplasia, and esophageal adenocarcinoma ***(Triadafilopoulos, 2002)***.

Retrosternal burning pain "heart burn" is the most common symptom of reflux, sure diagnosis is confirmed by endoscopy which demonstrate esopahgitis ***(Schwartz, 2002)***.

Twenty-four hours pH studies are the gold standard for determining where the patient has pathological gastro-esophageal reflux ***(Maher, 2001)***.

The great majority of patient can be managed by simple conservative programs, others need some medication. In home, proton pump inhibitions is still considered to be the gold standard treatment.

Despite significance advances in medical treatment still number of patient show persistence or recurrent symptoms, also, long-term therapy is associated with high costs and relapse. Antireflux surgery advised to these patient.

Antireflux operation is done either by open laparotomy or laparoscopically although experience is still some what limited, the same operation are feasible laparoscopically as by open laparotomy but with a much simple post operative course ***(Feldman, 2001)***.