in order to offer adequate pleural space visualization and easier management in biopsy, pleural debridement and talc insufflation. In this article, the author did not report any information about patient position, kind of access and anaesthetic technique. In our opinion, this novel approach could be considered as a talc slurry ‘under visual control’. It is well-known that, when compared with talc slurry (TS), thoracoscopic talc insufflation is associated with a reduction in recurrence and with a major successful rate [3]. As reported in a prospective not randomized trial comparing TS vs. TP by Stefani et al., chest pain was more common in the TS group and, in five patients initially selected for TS, severe chest pain with acute respiratory distress developed during, or shortly after talc instillation [4]. Anyway, further studies are mandatory to validate the approach proposed by the authors themselves.

References


eComment: Talc pleurodesis using rigid thoracoscope

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We have read with interest the report by Ishida and colleagues on the treatment of uncontrolled and symptomatic pleural effusion using talc pleurodesis by dedicated catheter through a flexi-rigid thoracoscope under local anaesthesia [1].

In our centre we perform talc pleurodesis under local anaesthesia in complicated pleural effusions using the standard rigid thoracoscope 0° that we normally use in video-assisted thoracoscopic surgery (VATS) procedures [2]. If there are no adhesion we can proceed to talc pleurodesis, either with talc slurry using 4 g of talc and local anaesthetic, or with talc insufflation with almost the same method as the authors, using a small catheter provided by the talc company fixed at the tip of the thoracoscope with Steri-strips. In patients with adhesions we proceed to VATS pleurodesis and adhesiolysis under double lumen general anaesthesia.

References
