Letter to the Editor

Completion pneumonectomy due to early complication of a first resection is a different operation from completion pneumonectomy performed months or years after a first resection

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I read with great interest the paper by Jungraithmayr and colleagues entitled ‘Indications and results of completion pneumonectomy’ [1] and I congratulate them on their results.

In a previous paper, my colleagues and I reported our experience with 47 patients who underwent completion pneumonectomy (CP) [2], including patients who underwent CP for early and late complications after a first resection, grouping the latter together with patients who underwent CP for benign diseases this way we tried to create two homogenous groups of patients, one of patients who underwent CP a few days after a first resection and another of patients who had the operation months or years after the first resection. Patients who underwent CP for early complications of the first resection had an operative mortality of 57%. So far we have an operative mortality of 54% (six out of 11) for CP performed for an early complication of the first resection, higher than that reported by others [3], but the operation was performed mostly in functionally compromised patients in whom preoperative data showed a high risk of mortality in case of pneumonectomy. However, we agree with Jungraithmayr and colleagues that CP in such patients is justified because there is a 100% lethal outcome without surgical intervention.

It appeared logical to us to group patients in that way, rather than grouping them in Jungraithmayr’s way that is, as emergency or urgent CP for complications after the first resection.

This classification includes in the same group (for instance in the emergency group) patients who had the first resection from 1 to 2160 days before CP.

Although it is known that an emergency or urgent operation carries a higher risk of mortality than a standard operation, it is also well known to surgeons who perform CP that a CP performed within a few days of the first operation is virtually never a technically demanding procedure and can usually be performed quickly and without blood loss. On the contrary, a CP performed months or years after the first resection is almost always a technically demanding, time consuming operation with high blood loss. Accordingly it does not seem correct to us to group patients who undergo CP either emergency or urgent operations, because CP performed within a few days of the first resection is a different operation from that performed after months or years. I imagine that the data that you reported on mortality may be misleading putting ‘apples and oranges’ in the same basket.

References


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Reply to the Letter to the Editor

Reply to Terzi and Calabro

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Many thanks for your comments and constructive criticism.

Let us clarify the point concerning our early high mortality and the term ‘emergency’ and ‘urgent’, which has possibly been misunderstood.