It is a fact that even after PLT the latissimus dorsi muscle still retains some reconstructive potential [4]. The thoracicodorsal artery, a branch of the subscapular artery, is the dominant vessel entering the proximal part of the muscle approximately 10 cm from its origin. The muscle is also nourished by segmental perforating vessels coming from the intercostal and lumbar arteries [5]. Both the proximal and the distal parts of the muscle can be used, although there is of course a certain degree of atrophy of the distal portion after division of the muscle.

We strongly insist that a reconstruction after PLT should be an interdisciplinary procedure involving both plastic and thoracic surgeons, especially in the use of the latissimus dorsi flap pedicled on segmental perforating vessels.

**References**


* Corresponding author. Address: Konstantinoupoleos Str. 34A, Holargos, 15562 Athens, Greece. Tel.: +30 210 6510388; fax: +30 210 6547695.

E-mail address: kallatha@otenet.gr.

**doi:**10.1016/j.ejcts.2007.06.002

**Letter to the Editor**

**Gastric outlet obstruction and respiratory complications after esophagectomy**

Richard D. Page*, Michael J. Shackcloth

Department of Thoracic Surgery, The Cardiothoracic Centre, Thomas Drive, Liverpool L14 3PE, United Kingdom

Received 10 May 2007; accepted 16 May 2007; Available online 26 June 2007

**Keywords:** Esophagectomy; Esophageal cancer; Respiratory complications

Lanuti and colleagues [1] are to be congratulated on their careful study of this difficult and controversial topic, which always leads to a heated discussion at esophageal meetings. Our approach is exactly the same as the authors, in that we only carry out a gastric drainage after esophagectomy with gastric reconstruction should the pylorus prove to be scarred and narrowed. Our impression is that most experienced esophageal surgeons take the same approach given the conflicting clinical evidence.

We would like to highlight another aspect of the early management of these patients in preventing the respiratory complications which the authors allude to when discussing the pros and cons of gastric drainage, namely the use of a nasogastric tube to keep the stomach empty. A particular problem of esophageal reconstruction is that when the mobilized stomach is placed transpleurally it is subjected to the negative intrathoracic pressure. As the patient swallows the stomach tends to dilate with air at the expense of the lung which can collapse. In addition to the problem of atelectasis, this leads to the added potential for respiratory aspiration of gastric contents which as we have recently shown [2] is universal after esophagectomy. We have also shown that nasogastric drainage of the mobilized stomach reduces this aspiration, although none of our patients were subjected to a gastric drainage procedure. As the patients’ lungs recover from surgery they show less tendency to collapse allowing the stomach to stay empty. As a result of our findings we have changed our practice to maintain nasogastric drainage for up to a week after surgery. In addition to a reduction in respiratory complications, we feel that the patients are able to resume oral intake with less clinical gastric outlet obstruction.

**References**


* The authors of the original paper [1] were invited to comment on this Letter to the Editor but felt that a reply was not necessary.

* Corresponding author. Tel.: +44 151 228 1616.

E-mail address: richard.page@ctc.nhs.uk (R.D. Page).

**doi:**10.1016/j.ejcts.2007.05.010

**Letter to the Editor**

**Surgical sealants for air leaks after pulmonary surgery**

Eric Lim*, Peter Goldstraw

Department of Thoracic Surgery, Royal Brompton Hospital, London, UK

Received 22 February 2007; accepted 4 June 2007; Available online 12 July 2007

**Keywords:** Surgical sealants; Hospital stay

We read with interest the study by Anegg et al. [1] on the effectiveness of TachoSil, a collagen patch coated with