It is a fact that even after PLT the latissimus dorsi muscle still retains some reconstructive potential [4]. The thoracodorsal 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


Letter to the Editor

Gastric outlet obstruction and respiratory complications after esophagectomy

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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


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* 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.

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Letter to the Editor

Surgical sealants for air leaks after pulmonary surgery

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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...
fibrinogen and thrombin to reduce air leak, duration of drainage and hospital stay.

We welcome their conclusion on the safety and efficacy of biosynthetic sealants to minimise air leaks, a finding which contrasts the conclusions of a recent Cochrane review based on the results of trials that were selected for inclusion [2].

Unfortunately, we cannot agree with their statement that theirs was the only trial of sealants to demonstrate benefits in both time to drain removal and hospital discharge. Our study at the Brompton Hospital published in February 2006 demonstrated significant reduction in the duration of air leak (1 vs 4 days; \( P < 0.001 \)), duration of chest drain (4 vs 5 days; \( P = 0.012 \)) and hospital stay (6 vs 7 days; \( P = 0.004 \)) [3].

Nevertheless, we would agree that further investigation is appropriate. However, with the demonstrated efficacy of surgical sealants, the question should not focus on efficacy compared to control, but rather relative efficacy between different forms of sealants.

References


We welcome their conclusion on the safety and efficacy of off-pump extracardiac Fontan procedure influences the outcome by reducing perioperative vasopressor needs, shorter intubation and intensive care/hospital stay rather than mortality [2,3]. Within 20 consecutive off-pump extracardiac Fontan procedures with no conversion to bypass, we observed two cases of mortality; they had preoperative pulmonary artery pressures of 18 and 13 mmHg, the latter having a preoperative ejection fraction of 45%. This observation is consistent with the findings by Hosein et al. [1]. Long-term pleural effusion and arrhythmia rates are also significantly reduced with off-pump extracardiac technique in addition to other known immediate advantages of avoidance from cardiopulmonary bypass in low-to-high risk groups [4,5].

We would like to thank the authors for the comprehensive review and the risk factor analysis.

References


Letter to the Editor

Factors influencing early and late outcome following Fontan procedure in the current era

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Keywords: Heart defects; Congenital; Pediatrics; Fontan procedure; Total cavopulmonary connection

We read with great interest the article by Hosein et al. [1] on the early and late outcome after Fontan procedure.