muscle flap from the 6th or 7th intercostal space are used. We avoid using flaps mobilizing the latissimus dorsi muscle or omental pedicles since such techniques require an extended surgical procedure associated with morbidity.

In summary, despite advances made over the last decades in surgical technique, postoperative care, and adjuvant therapy in NCLC patients, bronchial stump insufficiency still remains a major morbidity complication. In any case, BPF prevention by early recognition of possible risk factors and individualized approach for each patient in terms of bronchial closure and coverage is the state of the art. 

References


[14] With interest we read the recent institutional report of Panagopoulos and colleagues [1]. The authors are complimented on their meticulous analysis of 221 cases and the low rate of bronchopleural fistulas (BPF) at their institution. In their analysis, they identified preoperative respiratory infection and right pneumonectomy as the only independent risk factors for postoperative BPF. Interestingly, three of 14 patients (21%) who had received neoadjuvant therapy developed BPF (P=0.002), however, this finding did not turn out to be significant in the multivariate analysis. All three patients had undergone right-sided pneumonectomy and stump coverage by mobilization of the azygos vein and the surrounding parietal pleura or a pericardial flap following intra-pericardial pneumonectomy. In contrast, only two of the 207 patients without induction therapy developed BPF – invariably on the right side. While BPF occurred in these two patients already 7 and 12 days after surgery, it only emerged 14, 30 and 70 days postoperatively in those patients following induction therapy. And, if so, the underlying mechanisms would deserve further investigation in the light of a conceivable increase of multimodal protocols in the treatment of lung cancer [2].

References
