We would like to thank Dr Dato et al. for their comment [1] on our article [2]. In their letter to the editor [1], the authors are presenting their practice with regard to the management of patients with pectus excavatum (PE) deformity. Our article [2] aimed to present the facts related to the application of minimally invasive repair (MIRPE) for patients with PE in order to help clinicians and patients make a decision based on the best clinical practice. Our article also highlighted conflicts within the literature and pointed out the need for further research based on larger series and rigid protocols, in order to strengthen the published literature.

The frequently debated ‘Ravich-versus-Nuss’ and ‘minimally invasive-versus-less invasive’ are discussions that many clinicians enter into with a strong and unwavering opinion. However, it is of paramount importance for clinicians to acknowledge that alternate techniques can provide equally good results and that patients should be allowed the freedom to choose their treatment. The decision for treatment should be unbiased and based on facts and informed consent, especially for clinical conditions where cosmesis is the primary reason behind treatment.

The cost of providing these procedures is an important issue and should be carefully considered prior to offering any treatment. MIRPE remains expensive and cannot be offered widely within government-funded health-care systems to everyone in need (the majority of patients live in underdeveloped or developing countries, while countries of the western world are currently faced with economic crisis and limited health budgets).

The effectiveness of the Ravich-versus-MIRPE should be the real issue of debate. Effectiveness should be judged not only on the anatomic correction of the deformity, but its ability to treat the underlying cause for these patients who seek medical/surgical correction, which in the vast majority of cases is cosmetic with social and psychological roots. As such, we talk about a group of patients during their early years of development, where social and psychological problems can have a major impact on their future behaviour and quality of life. We, the medical community, should pay more attention to preventative mechanisms with early and correct medical and psychological counselling of our potential future patients and their families.

In their letter to the editor [1], Dr Dato et al. are offering MIRPE to their patients up to the age of 22, while they seem to favour the Ravich repair technique for older patients. It would be interesting to know the basis for this decision and any results they may have to support this decision. On the same ground, and bearing in mind that pain remains the most frequent and difficult to manage issue related to MIRP [3], it is very interesting to know what the authors mean by ‘borderline skeleton age’ and how ‘CT-chest with 3D-reconstruction’ can help us reduce pain, in this particular group of patients. Therefore, it would be of great interest if Dr Dato et al. could share with us their protocol and their results that support this claim.

In conclusion, we agree with Dr Dato et al. that careful patient selection is mandatory for chest wall repair and we would like to recommend that informed consent should play a vital role in our discussion with patients who would benefit from the implementation of a repair procedure. Quality data, including patient satisfaction surveys, should play pivotal role in helping to justify any decision regarding the approach used to treat patients with PE.

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