Reply to Rena and Casadio

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I would like to thank Rena and Casadio for their keen interest in my case study [1, 2]. The authors have a number of concerns that they would like to discuss. First, I think the authors are missing the point of the study, which concludes that strict haemostasis should be achieved if the pleura is seen to be opened inadvertently during a mediastinoscopy; thus, even a mild bleeder should not be left (this is what not to do). The hypothesis of the development of the haemothorax was based retrospectively after the complication developed and, as this is a rare, unreported complication and we all may experience a degree of mild acceptable ooze at the end of a mediastinoscopy, it was not avoided at this stage. I wonder from using the phrase ‘it is well known’ by the authors, how many of these problems they have seen before?

Second, the authors are misinterpreting a chest X-ray that was performed 24 h after the procedure (as stated) and shows a localized haematoma, while the immediate postoperative one (unfortunately not in the manuscript) – on which the decision was made to insert a chest drain – showed a right-sided collection with no signs of loculation. I agree that there could be a point in earlier intervention, but we opted for a more conservative approach because the patient was stable. On feeling that the drain would not be able to evacuate the haematoma properly, surgical intervention was decided on. I would also disagree with the approach the authors suggest (a limited axillary thoracotomy), because a posterolateral thoracotomy [after a failed video assisted thoracoscopic surgery (VATS)] has good evidence of safety and provides excellent exposure to the lower paratracheal and subcarinal space [3] (where sampling was performed during mediastinoscopy in this patient) and is a more commonly practised procedure by all thoracic surgeons.

Finally, the authors are concerned about additional procedures done during the thoracotomy. A mediastinal lymphadenectomy has no additional morbidity in our hands, because it is a routine during our resections for lung cancer patients and would provide a definite diagnosis in this patient’s case. The partial decortication was necessary because it is well known to thoracic surgeons that a collapsed lung (after selective ventilation) is much more difficult to expand if surrounded by a thick cortex, with the chance of being left with a space problem. Again, this should be left to the discretion of the surgeon during the procedure to weigh potential risks and benefits.

REFERENCES