Towards a standardized approach for video-assisted thoracoscopic surgery lobectomy

Gaetano Rocco*

Division of Thoracic Surgery, Department of Thoracic Surgery and Oncology, National Cancer Institute, Pascale Foundation, Naples, Italy

* Corresponding author. Division of Thoracic Surgery, Department of Thoracic Surgery and Oncology, National Cancer Institute, Pascale Foundation, Via Semmola 81, 80131 Naples, Italy. Tel: +39-0815903262, fax: +39-0815903823; e-mail: gaetano.rocco@btopenworld.com (G. Rocco).

Keywords: Lobectomy • Video-assisted thoracoscopic surgery • Lung cancer

There is little doubt that standardization of care tends to improve outcomes and costs. Along this line, the adoption of the anterior approach for video-assisted thoracoscopic surgery (VATS) lobectomy described by McElnay et al. [1] in this issue of the EJCTS has led in their experience to an increased resort to VATS lobectomy and shorter hospitalizations. Although the value of the anterior approach can hardly be discussed, the existence of a linear relationship between anterior approach and increased utilization of VATS lobectomy needs further investigation since it may not depend only on the acquisition of dedicated surgical skills. In this report, the inclusion criteria for VATS lobectomy are not thoroughly specified and the reader would have benefitted from the appreciation of the reasons for conversion. In this setting, the authors report that, in the event of a conversion, they would advocate resort to posterolateral thoracotomy probably depending on the severity of the emergency. This statement contradicts the authors’ prevailing view on the anterior one as the best approach to control the bronchovascular structures at the hilum. In addition, the authors’ experience seems to support the idea of a stepwise training from open to VATS through an anterior approach. This view may conflict with the emerging opinion among advocates of VATS lobectomy supporting direct VATS training. Be that as it may, my impression is that this contribution represents both a wasted opportunity and an interesting future project to prospectively compare, possibly in a randomized fashion, the approach that the two most senior surgeons were using before training with the anterior one currently used in their practice. In this context, one aspect of the Bristol experience that may have influenced the results of this study is that the learning curve could have been different for the surgeon already used to a ‘modified’ anterior approach.

Prior to renouncing a priori to versatility, which is still one fundamental surgical creed, further investigation is needed. One of the strong points used by the advocates of VATS lobectomy has always been that this procedure is the same as open surgery. A feature of the latter is the possibility of addressing differently located target lesions in the chest by using different thoracotomies (i.e. bronchus first technique). However, McElnay et al. [1] propose the argument to select the anterior approach to maximize patient safety and surgeon confidence in VATS lobectomy by abating the steepness of the learning curve. Indeed, the triad including anterior muscle sparing thoracotomy, anterior VATS approach and uniportal VATS is certainly appealing and may represent a consolidated pathway to ensure minimally invasive surgical expertise for lobar resections in the future.

REFERENCE