with an increased risk of local injuries of adjoining nerves and vessels. I agree, however, that an infracardiac approach to the right axillary artery can also be difficult, especially in obese patients. This is one of several reasons why I prefer a common carotid artery for cannulation and the access on the neck [2, 3]. This approach offers the fastest and simplest access to a large artery in the human body, taking just few minutes even in obese patients. Especially in these patients, the groin access to femoral artery takes more time, and is associated with an increased risk of infection, which, to date, we have never observed on the neck. As I emphasized in my contribution to the Great Debate [2], we used it in a lot of obese patients, and have never encountered a problem. Recently, we used this approach without considerable difficulties in an acute dissection patient, who weighed 180 kg and was only 178 cm tall. Moreover, the adjoining jugular vein offers the possibility of venous cannulation and establishment of cardiopulmonary bypass before opening the chest without the necessity of femoral cannulation [4]. Such an approach can be advantageous in redo or emergent aortic surgeries as opposed to Almdahl’s suggestion to perform the sternotomy first. Putting an unstable patient with tamponade on bypass before sternotomy ensures the establishment of sufficient organ perfusion, and even prevents an uncontrolled increase of blood pressure after opening the chest and subsequent aortic rupture risk. I am aware that some surgeons are still reluctant to use the carotid artery for cannulation, but after using it in more than 1000 cases, I can just repeatedly state: try it and make your own opinion.

REFERENCES


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Does adjuvant chemotherapy following complete resection also have a significant effect on overall survival of thymic epithelial tumours?

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I read with great interest the recent article by Ruffini et al. [1] regarding a cohort study of thymic epithelial tumours using the large database of the European Society of Thoracic Surgeons. I would like to thank the authors for publishing the invaluable data.

They analysed the largest database of patients with thymic epithelial tumours and their findings indicate that adjuvant therapy provides significant benefit on overall survival. In their forest plot with propensity score, there was not an effect modification by specific subgroup, which may mean that adjuvant therapy will benefit both thymoma patients and thymic carcinoma patients. Notably included in the large database was information on adjuvant chemotherapy, whereas it is often lacking in other databases on thymic epithelial tumours. Compared with radiotherapy for thymic epithelial tumours, chemotherapy has been less investigated [2, 3].

They mentioned in the paper that the effect of adjuvant radiotherapy was nearly as identical as that of the whole adjuvant therapy. I am interested in the effect of adjuvant chemotherapy (alone or with radiotherapy) on overall survival of thymic epithelial tumours or any histological subtype. Previously, a significant benefit of adjuvant chemotherapy on overall survival was not shown for thymoma or thymic carcinoma patients [2, 4]. In their study, was adjuvant chemotherapy as effective as adjuvant radiotherapy and significantly effective on overall survival of thymic epithelial tumours or any histological subtype? Also was the effect of adjuvant chemotherapy different between histological subtypes? I would appreciate any input from the authors in these regards.

Again I would like to thank the authors for the opportunity to read and comment on this paper.

REFERENCES


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Reply to Hamaji

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We would like to thank Hamaji [1] for his interest in our study and for his enquiry regarding the role of postoperative (adjuvant) chemotherapy (CT) with or without radiotherapy (RT) following complete resections in thymic malignancies [2].

The European Society of Thoracic Surgeon (ESTS) thymic retrospective database was designed to include all thymic tumours submitted to surgical resection from 1990 to 2010 from 35 European and non-European institutions. A total of 2265 patients were included in the data set and analysed.

THYMOMA

Among 1519 patients with thymoma receiving a complete resection (R0) and with complete vital status information, 582 (38%) received any form of adjuvant therapy after resection. Of these, 28 (5%) received CT only, 118 (20%) CT + RT and 436 (75%) RT only. Univariate analysis, using no treatment as reference, showed that the addition of postoperative CT to radical surgery did not result in a significant survival advantage [HR: 1.92, 95% (Confidence Interval) CI: 0.78–4.75, P = 0.16]. The multivariate-adjusted model indicated an independent