ACKNOWLEDGEMENTS

We salute the strength and the determination of all the healthcare professionals committed to patients’ care during the 13 November Paris attacks, and we pay homage to the patients and their relatives.

Conflict of interest: none declared.

REFERENCES

speciality’s competencies are desperately needed. European trauma surgery tends to fuse with orthopedics leaving the responsibility in treating the injury of the torso in a sort of, ‘no man’s land’. Emergency surgery is still in baby-doll, while the specialization fury makes general surgeons able to perform basic life-saving procedures via laparotomy and/or thoracotomy, an extinct species.

The heterogeneity of the specialization schemes throughout individual European countries and the structural varieties and differences in hospital/clinic settings [5] makes a ubiquitous chest trauma care model impossible. However, either in a terror related multiple or mass casualty situation, at least 1 out of 3-5 victims, the thorax will be involved if the injury severity score is over 15 [4, 6].

From a thoracic surgical consultant point of view, most of acute chest trauma is terribly simple, as the ‘bon mot’ reveals, 95% simple and 5% terrible. The question deciphered, now reads, ‘is there a real need for a board certified thoracic surgical specialist in all major trauma teams, and if yes, do we have the manpower? Huge trauma centres have access to a thoracic surgical standby or in-house specialists. However, as experience demonstrates, mass casualty situations, by definition, overflow even the largest capacities. The jury is still out in the one big centre versus many smaller yet capable facilities debate [7]. The majority of chest injuries (injury severity score >15), can be managed initially by drainage alone: a trained junior doctor’s decision and procedure [5]. Emergency service policies, ‘stay and play’ versus ‘scoop and run’, vary from country to country. Terror attack sites are unsafe, a second attack is a real danger, therefore, extensive, on-site management is undesirable. Notably, hospitals are highly valued, soft and easy terrorist targets. There are plenty of out of box points to consider, when the thoracic surgical tasks are to be listed in a terror attack.

‘Si vis pacem para bellum’, meaning, if you want peace, be prepared for war. Our responsibility intertwined among 3 different roles: surgeons, educators and team leaders. Effective leadership does not exist without preparedness, which means regular major trauma event exercises. Elements of damage control thoracic surgery need to be drilled [8]. Stabilized chest injury patients, complications such as retained haemothorax, thoracic empyema and permanent flail chest on ventilator are unquestionably candidates for referral to our units and departments. The burning question remains, in consideration of the capacity and capability of the departments/units, how best to fill beds and assign staff originally optimized for minimally invasive lung cancer cases or for cardiac surgery patients? A variable yet significant percent of cases chest trauma is only a part of the problem: those are the multi and polytrauma victims. A significant amount of chest trauma involves heart, major vessels or oesophagus: organs not covered throughout all countries by our core competencies. It would be a mistake to reduce the problem to the capacities and skill sets of personnel. The cardiopulmonary bypass machine and cell saver are not standard equipment in support of general thoracic surgery theatres. Our mindset needs a reset. Acute chest trauma as an entity in itself, is still in the peripheral vision of both of our continental professional bodies. A low degree of our awareness is reflected by the fact, in which acute chest trauma never exceed the 3% of the presentations in any of the 2014–16 annual meetings of the European Society of Thoracic Surgeons. While no conclusion missed to stress the importance of the thoracic surgeon’s participation, no one mentioned the too low caseload issue. In the light of less than 8–10 major chest trauma cases necessitating immediate thoracotomy per year [9], a full-time consultant level thoracic surgeon at trauma stand by 24/7/12 seems to be a luxury, few countries possess. Mass casualty in terror attacks generates an unexpected flow to what is manageable only by triage, communication and consideration of application of damage control surgery [8].

In summary, rather than pursuing a mirage of thoracic surgeon specialists permanently embedded into every mass trauma team, where they have very few job to do, junior surgeons should be trained to control emergency thoracic scenarios. In reality, the consultant thoracic surgeon’s skill sets usually exceed the task, thereby rendering it an unwise use of limited resources. Once again, here we are faced with the issue of education. One will admire the few lucky centres in which we find in-house thoracic surgeons, but many countries do not have sufficient number of trained hands to fill the ranks. What is expected, is a safety network of thoracic surgical consultants as a contingency and backup strategy. What is our responsibility, is to ensure all junior surgeons are indeed mission-ready and fully capable to perform effective, safe thoracic drainage and emergency thoracotomy. Translation of knowledge in postoperative care is essential, where the devil of failure too often resides. All these procedures likely seem too trivial for the readership of the European Journal of Cardio-Thoracic Surgery (EJCTS), but 1 step beyond the protective wall of our (cardio)thoracic wards will adversely surprise them. We should have a firm foothold in the complexity of trauma care. The multidisciplinary team concept developed originally for TB cases, followed by cancer treatment, should be applied to the management in treating chest trauma, too. The family of thoracic surgeons should be ready to answer the call of our professional and patriotic duties in the next terror attack.

REFERENCES