eComment. Muscle sparing thoracotomy for the apical posterior mediastinal lesions

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We thank Yang et al. for their study about the resection of the posterior mediastinal lesions [1]. We want to add a comment on the approach for the posterior mediastinal tumours.

We agree that thoracoscopic resection of posterior mediastinal tumours can be performed successfully with decreased operation time, hospital stay and patient discomfort. But we think that those that are located to the apex of the hemithorax should not be resected thoracoscopically. Authors wrote that thoracoscopic surgery was associated with reduced operation time, blood loss and hospital stay. These were good results but there was one complication (brachial plexus lesion) that was higher in the video-assisted thoracoscopic surgery (VATS) group. We think that this complication is much more important than the benefits mentioned above.

Most posterior mediastinal tumours have a benign character [2]. No surgeon wants such a complication after performing surgery for a benign lesion. Also, the thoracoscopic approach near to the great vessels carries the risk of massive haemorrhage because of the limited manoeuvrability. At our institution, we used muscle sparing thoracotomy on a patient who had a lesion at the apex of the right hemithorax. More than half of the operation was performed with blunt finger dissection. We did not spend too much time for the exposure, as is so in VATS procedures, and for the dissection. Closure of the hemithorax was also not time-consuming because there was not a lot of muscle tissue to be cut through.

Authors declared that they used two chest tubes after the operation. We think that placing two chest tubes for these kind of surgeries adds to the discomfort of the patient. Chest tubes can be the only annoying thing after thoracic procedures for the patients. In general, we use single chest tubes for all procedures performed other than lung surgery. We place the chest tube to the apex of the hemithorax and open a hole on the lower part of it to drain any effusions. Also, cutting the specimen before taking it out of the thorax is a better approach than to enlarge the utility thoracotomy [3].

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References