Letter to the Editor

Completion pneumonectomy due to early complication of a first resection is a different operation from completion pneumonectomy performed months or years after a first resection

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Received 9 September 2004; accepted 7 October 2004; Available online 6 November 2004

Keywords: Completion pneumonectomy; Postoperative complication; Lung resection

I read with great interest the paper by Jungraithmayr and colleagues entitled ‘Indications and results of completion pneumonectomy’ [1] and I congratulate them on their results.

In a previous paper, my colleagues and I reported our experience with 47 patients who underwent completion pneumonectomy (CP) [2], including patients who underwent CP for early and late complications after a first resection, grouping the latter together with patients who underwent CP for benign diseases this way we tried to create two homogenous groups of patients, one of patients who underwent CP a few days after a first resection and another of patients who had the operation months or years after the first resection. Patients who underwent CP for early complications of the first resection had an operative mortality of 57%. So far we have an operative mortality of 54% (six out of 11) for CP performed for an early complication of the first resection, higher than that reported by others [3], but the operation was performed mostly in functionally compromised patients in whom preoperative data showed a high risk of mortality in case of pneumonectomy. However, we agree with Jungraithmayr and colleagues that CP in such patients is justified because there is a 100% lethal outcome without surgical intervention.

It appeared logical to us to group patients in that way, rather than grouping them in Jungraithmayr’s way that is, as emergency or urgent CP for complications after the first resection.

This classification includes in the same group (for instance in the emergency group) patients who had the first resection from 1 to 2160 days before CP.

Although it is known that an emergency or urgent operation carries a higher risk of mortality than a standard operation, it is also well known to surgeons who perform CP

that a CP performed within a few days of the first operation is virtually never a technically demanding procedure and can usually be performed quickly and without blood loss. On the contrary, a CP performed months or years after the first resection is almost always a technically demanding, time consuming operation with high blood loss. Accordingly it does not seem correct to us to group patients who undergo CP either emergency or urgent operations, because CP performed within a few days of the first resection is a different operation from that performed after months or years. I imagine that the data that you reported on mortality may be misleading putting 'apples and oranges' in the same basket.

References


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doi:10.1016/j.ejcts.2004.10.004

Reply to the Letter to the Editor

Reply to Terzi and Calabro

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Received 5 October 2004; accepted 7 October 2004; Available online 23 November 2004

Keywords: Completion pneumonectomy; Condition of patient; Complication; Mortality

Many thanks for your comments and constructive criticism.

Let us clarify the point concerning our early high mortality and the term 'emergency' and 'urgent', which has possibly been misunderstood.
In our series, in an elective situation CP has a mortality of 8%, whereas in an urgent or emergency situation CP has a much higher operative mortality of 23% and 54%, respectively. So it is not so much the late CP that is responsible for the high mortality, but rather the fact that patients are referred to the OR in an emergency or in an urgent condition. We classified the ‘high-risk patients’ into the following two groups: ‘emergency’ and ‘urgent’. The expression ‘urgent’ refers to the condition of a patient in which we are able to improve his state of health prior to CP in order to perform better postoperatively, i.e. having a greater chance of survival, whereas emergency means immediate referral to the operating room without having the chance to stabilise the patient’s condition. Moreover, the classification ‘emergency’ and ‘urgent’ refers to the onset of a complication, not to the time between first resection and CP.

The reason for the higher risk is the patient’s condition prior to CP: most of them had emphysema or an anastomotic insufficiency that led to a preoperative septic condition with fever, cardiocirculatory instability and possibly respiratory failure. Therefore, it is not the CP itself that is responsible for the higher risk but the complication that leads to the final step of CP.

Thus, we argue that the time span between the first resection and CP is not as important as the patient’s condition immediately before CP.

The case for a ‘sandwich’ course in plastic surgery

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Received 16 August 2004; accepted 21 September 2004; Available online 19 October 2004

Keywords: Muscle flap; Chest wall; Diaphragm

I read with interest the manuscript by Rathinam et al. illustrating a very well devised technique of reconstructing a challenging defect in the chest wall with a Marlex methacrylate sandwich [1]. Although the paper contains some controversial statements (i.e. the limitations of Goretex patches), I believe one of its major highlights resides in emphasizing how the thoracic surgeon should be familiar with the techniques of chest wall reconstruction and the use of muscle flaps for intrathoracic usage both for benign and malignant processes [2,3]. A basic competence in this field, often perceived as a ‘nowhere land’ between thoracic and plastic surgery, should be required from future thoracic surgeons and included in the European thoracic surgical training curricula, possibly relying on the collaboration of the local plastic surgery training programmes.

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References


Reply to the Letter to the Editor

Reply to Rocco

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Received 17 September 2004; accepted 21 September 2004; Available online 27 October 2004

Keywords: General thoracic surgery; Reconstruction; Surgical training

We thank Mr Rocco for his valuable comments regarding our article.

We agree that the thoracic surgeon should be familiar with the techniques of chest wall reconstruction and the use of muscle flaps.

These skills are very useful in malignant, benign and infective settings in cardio-thoracic surgery.

We reviewed the abstracts published in the CTSNet journals (European Journal of Cardio-thoracic Surgery, Annals of Thoracic Surgery, Journal of Thoracic and Cardiovascular Surgery and Asian Annals of Cardio-thoracic Surgery) on chest wall reconstruction to see the involvement of plastic surgeons in the published series. We found that 10 of the 18 series (55%) had plastic surgeons involved in the procedure.

Series with plastic surgical involvement

KA Mansour 200 patients Ann Thorac Surg 73:1720-1726
H Koch 36 patients Eur J Cardiothorac Surg 21:874-878
W Raffoul 3 patients Ann Thorac Surg 72:1720-1724
C Deschamps 197 patients Thorac Cardiovasc Surg 117:588-592
D Lardinois 26 patients Ann Thorac Surg 69:919-923
GL Walsh 51 patients J Thorac Cardiovasc Surg 0048-0060
AR Chapelier 38 patients Ann Thorac Surg 77:1001-1007
KA Mansour 21 patients Ann Thorac Surg 55, B38-842
PC Pairolero 100 patients J Thorac Cardiovasc Surg 90, 367-372
KM Al-Kattan 30 patients Ann Thorac Surg 60:1372-1375