We have read with interest Dr Zielinski’s letter and we thank him for his comments.

Different authors stated that partial sternotomy permits excellent visualization of the thymus gland, its vascular attachments, and all peripheral tissues in the mediastinal region limited by the thyroid gland superiorly, between the phrenic nerves laterally, and pericardial sac and mediastinal pleura inferiorly [1-3]. In our study, we took separate margins for frozen section analysis to make sure no thymic tissue is left behind, and to support our belief that the manubriotomy approach is equal to the sternal approach in the extent of dissection, with the advantage of being less invasive.

Postoperative morbidity was encountered in the sternotomy approach group of our study in six patients out of the 26 patients (23%). We did not differentiate the morbidity in major and minor; we mentioned all abnormal deviations encountered disregarding severity. In a literature review, the operative morbidity in transternal thymectomy was found to be between 4 and 33% [4].

In our study, six patients who were operated upon through the transternal approach had radiological evidence of pneumonitis; in four patients (15.4%) with clinical evidence of chest infection, and in two patients without clinical correlate. This is not surprising because patients with myasthenia gravis face major pulmonary problems as part of their disease process; as the myasthenic forced vital capacities are significantly lower than those for normal subjects. Due to expiratory weakness, cough efficacy is reduced and may lead to postoperative pulmonary complications [5]. The preoperative data of the patients in the sternotomy group of our study have demonstrated those findings in the form of a FVC of 67.2% and a FEV1 of 67% of predicted values.

According to the literature, in transternal thymectomy the incidence of retention of respiratory secretions is 10%; of atelectasis is 7%. Pneumonia develops in 1-14% of patients, whereas upper airway infections afflict 1.5-35% of surgical patients [4].

As regards the non-pulmonary complications in our transternal thymectomy group, they comprised wound infection in two patients with mediastinitis (7.7%), and one patient with phrenic palsy (3.8%). The following incidences of surgical complications are quoted in the literature for transternal thymectomy: wound infection 1-7%, sternal disruption 1-4%, and injury to the phrenic nerve 0-4.5% [4].

In conclusion, we would like to emphasize that this comparative study is not trying to discredit the procedure of transternal thymectomy, but is claiming that there are postoperative advantages of the manubriotomy approach with the same extent of resection which a sternotomy allows.

References


Furthermore, recent expression profile studies [4,5] demonstrated that gene expression profiles differed in the neoplastic and non-neoplastic tissues of smokers versus non-smokers. To date, it is not known whether these changes are unique to smokers who develop lung cancer or are present in all smokers and whether these changes are associated with the presence of concomitant COPD.

To our best knowledge an analysis of the possible molecular signature of COPD indicating a predisposing status toward the development of lung cancer has never been realised. Moreover, inside the molecular signature of COPD/Lung Cancer patients, an analysis of predisposing factors possibly indicating a worst (or better) prognosis has never been realised either.

In our opinion, it is now time to match and reconcile basic comprehensive information coming from molecular and cellular biology with those coming from clinical experiences (as that reported in [1]) to foster, in a translational attitude, further investigation.

References


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Reply to the Letter to the Editor

Reply to Spina et al.

Molecular studies in lung cancer patients with chronic obstructive pulmonary diseases

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We are grateful to Spina et al. for their comments concerning our work [1]. In accordance with their hypotheses, it is necessary for the molecular aspect of lung cancer to be studied more thoroughly in general and to deepen into certain subpopulations affected with that neoplasia.

Currently, our sample consisting of 2994 cases of lung cancer from the GCCB-S, is being used to measure the expression of over 30 proteins employing the tissue arrays technology [2]. In doing so, we expect to be able to answer some of the questions raised.

References


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Letter to the Editor

Radical lymphadenectomy in esophageal adenocarcinoma

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We read with interest D’Journo and colleagues’ [1] article on the comparison between standard and extended mediastinal lymphadenectomy for esophageal adenocarcinoma. We have several criticisms on the paper. First, the authors’ definition of standard and extended lymphadenectomy is at variance with those of the consensus conference of the International Society for Diseases of the Esophagus (ISDE) [2]. The authors’ considered lower mediastinal and subcarinal nodes in the mediastinum and paracardial, lesser curvature, celiac and left gastric nodes in the abdomen as ‘standard lymphadenectomy’ and the addition of common hepatic and splenic nodes in the abdomen and right and left superior mediastinal nodes as ‘extended lymphadenectomy’ [1]. In fact, according to the consensus conference definitions [2], there is no difference in the extent of abdominal lymphadenectomy between the standard and extended surgeries. Also, extended lymphadenectomy is actually the addition of the right recurrent, paratracheal and upper paraesophageal nodes to the standard procedure. The addition of right and left superior mediastinal nodes is a ‘total mediastinal lymphadenectomy’.