We read with interest the article by Molnar et al. [1] on the advantages of videothoracoscopic (VATS) lung biopsy (LB) using harmonic scalpel (HS) versus the traditional endostapler in two randomized groups. The average length of the procedure was 46.9 min for endostaplers versus 30.7 min for HS (16.2 min in favor of HS). However, at chest tube removal timing this tendency changed (30.6 h after LB with endostapler and 40.2 h after LB with HS). Mean hospitalization stays were similar (7.2 days for endostaplers and 7.6 days for HS). The conclusions were that the vibration method is not inferior to the standard technique and offers a safe alternative to endostapler LB.

We do not know how many of the patients included in the study by Molnar et al. [1] were oxygen-dependent or had an acute illness that may prolong their hospital stay after LB, but a mean stay of 7 days appears to be excessive. Moreover, a mean of 5 days after chest tube removal and discharge from the hospital. It is supposed that a shorter and safer technique should permit earlier chest tube removal and reduced hospital stay than the conventional procedure; however, this study showed no improvement in these terms. In our opinion, safe chest tube removal after LB can be performed earlier, and consequently hospital stays can be reduced significantly, even with the use of common endostaplers.

Russo et al. [2], in a prospective, nonrandomized trial demonstrated that chest tube removal within 90 min of VATS lung biopsy, in selected patients, could be accomplished safely. In another study, Blewett et al. [3] did not use chest tube drainage after open lung biopsy for diagnosis of interstitial lung disease. In 32 patients no complications occurred and no patient required overnight observation or hospital admission. Chang et al. [4] reported a series of 62 patients undergoing outpatient thoracoscopic LB with 5% of admissions. They concluded that outpatient thoracoscopic LB was safe and effective. In our group we have developed a policy of early removal of chest drainage after VATS LB since 1992. Of the 146 patients included, the chest tube was removed in 135 patients (92.4%) less than an hour after the procedure. In nine patients (6.2%) the chest tube was removed 4—24 h after the procedure due to initial air-leak. In only two cases (1.4%) was the tube removed after the second postoperative day. Median hospital stay was 1.2 days (range: 0—7 days). There were 32 outpatient procedures since 2001.

We thank Fibla et al. [1] for their letter. Answering their questions, first, we did not have oxygen-dependent patients nor acute cases in our randomized study [2]. It would not have been proper to enroll critically ill patients in a new technology project. The mean hospital stay calculated from the incriminated (‘excessively long’) 7 days is partly due to an usually 2-day (1—5 days) long preoperative investigative period in our tertiary referral center with a waiting list less than 2 weeks. Our postoperative period ranging from 2 to 16 days with an average of 4.6 days, still can be regarded as unnecessarily long by those who focus exclusively on hospital stay. However, we consider other aspects equally important. Reducing operative time, improving specimen quality, avoiding metal clips, and patient’s safety were also among our aims. The particular circumstances of a certain procedure include not only medical aspects but also socio-legal aspects. If the existing legal/judicial system is a strongly patient friendly one — like ours — an even minor out-of-hospital postoperative complication can lead to the verdict of professional negligence. The hospital manager’s new mantra: 1 day surgery for reducing costs while increasing patient satisfaction. The result is an early discharge race. Nevertheless, sending home a patient is a double-edged sword. Should anything happen afterwards related (or supposedly related) to the previous procedure, the surgeon is at the mercy of the judge. Did anybody ever hear a hospital manager accused of pressing too hard his doctor? Ought we make our managers satisfied or should we make our patients and their lawyers happy? Are we still responsible professionals rather than health-care employees [3]? Are we still bound to the Hippocrates’ Oath—to protect our patients and defend ourselves? Obviously the answer is a very complex one. What we deny is a race in hours/days of tubing. Safety and patient appeasement are not exactly the same. How long should we keep the average patient in hospital to avoid that

**References**


**Reply to the Letter to the Editor**

Reply to Fibla et al.

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We thank Fibla et al. [1] for their letter. Answering their questions, first, we did not have oxygen-dependent patients nor acute cases in our randomized study [2]. It would not have been proper to enroll critically ill patients in a new technology project. The mean hospital stay calculated from the incriminated (‘excessively long’) 7 days is partly due to an usually 2-day (1—5 days) long preoperative investigative period in our tertiary referral center with a waiting list less than 2 weeks. Our postoperative period ranging from 2 to 16 days with an average of 4.6 days, still can be regarded as unnecessarily long by those who focus exclusively on hospital stay. However, we consider other aspects equally important. Reducing operative time, improving specimen quality, avoiding metal clips, and patient’s safety were also among our aims. The particular circumstances of a certain procedure include not only medical aspects but also socio-legal aspects. If the existing legal/judicial system is a strongly patient friendly one — like ours — an even minor out-of-hospital postoperative complication can lead to the verdict of professional negligence. The hospital manager’s new mantra: 1 day surgery for reducing costs while increasing patient satisfaction. The result is an early discharge race. Nevertheless, sending home a patient is a double-edged sword. Should anything happen afterwards related (or supposedly related) to the previous procedure, the surgeon is at the mercy of the judge. Did anybody ever hear a hospital manager accused of pressing too hard his doctor? Ought we make our managers satisfied or should we make our patients and their lawyers happy? Are we still responsible professionals rather than health-care employees [3]? Are we still bound to the Hippocrates’ Oath—to protect our patients and defend ourselves? Obviously the answer is a very complex one. What we deny is a race in hours/days of tubing. Safety and patient appeasement are not exactly the same. How long should we keep the average patient in hospital to avoid that
particular one, who will develop complication and will sue us? A fair number of chest patients could be operated on even without leaving tubes behind at all. The problem is that no one of us is able to predict convincingly those patients who would really need the tube. We are afraid that with the present force of push of the law the hopes for an ideal solution are fading away.

Fibla is arguing with something we did not state and is correcting a direction we never followed. We refrained even from economical calculations as this can be misleading in different socio-economical environments. Feasibility of experiences of others needs a full picture of the context of where the report in question was born. We hope that we have been able to dissolve the clouds of misunderstandings and Fibla et al. [1] are sufficiently convinced: harmonic scalpel is not inferior to the standard methods. Our animal studies [4] and clinical research [2] have proven it.

References


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