Letter to the Editor

Role of pre-operative lymphangiogram and lymphangioscintigraphy in the surgical management of spontaneous chylothorax

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We have read with interest the report from Christodoulou and co-workers [1] regarding the video-assisted thoracic surgery (VATS) treatment of spontaneous (non-traumatic) recurrent chylotorax.

As a matter of fact, due to the respiratory, nutritional and immunological implications, surgery is indicated whereas any conservative treatment failed in controlling this clinical condition. On the basis of their experience on a series of six treated patients, the Authors do conclude that recurrent or persistent non-traumatic chylothorax may be successfully treated by video-assisted right supradiaphragmatic thoracic duct ligation.

We strongly agree with the Authors on their conclusion since we have observed similar evidences in our own experience (adopting the same surgical approach) on 12 cases (10 right sided, 2 left sided) observed and treated in our Institution in the period between January 2001 and December 2005 (in the same period, two cases were treated by an open thoracotomy approach because they were previously submitted elsewhere to video-assisted thoracic duct ligation). Before surgery, all patients had a pleural drainage for almost 2 weeks with a persisting leak >300 ml/day. Four patients developed chylothorax as a result of thoracic irradiation and four cancer (three lymphoma, one breast cancer). In particular, we report a mean operating time of 92 ± 14 min with no mortality or major perioperative complications. A single chest drain was left in place after operation connected with a very mild continuous aspiration for the first 24 h. The drain was removed 5 ± 1 days after the operation (mean). Patient controlled anaesthesia (PCA) and physiotherapy were adopted in all cases. A <100 ml/day leak persisted post-operatively in one patient and was conservatively treated (chest drain, parenteral nutrition—no oral intake) up to the complete resolution 14 days after surgery. Mean hospital stay was 6.2 days (range 3–15).

In this correspondence, we would like to briefly and amicably address the Authors requesting their opinion on the value of pre-operative lymphangiography and lymphangioscintigraphy in this clinical setting. In our series we performed a lymphangiography in 10 patients and lymphangioscintigraphy in 4. These diagnostic procedures did not carry any morbidity and allowed us to obtain a precise definition of the type and location of the chylous leak. Thus, the surgical procedure driven by the results of pre-operative evaluation and selective duct ligation could be accomplished. Whereas aberrant anatomy was pre-operatively identified, the ligation of the visible branches of the thoracic duct was followed by a regional poudrage (2–5.5 g of talc). We strongly advise this kind of pre-operative evaluation since it is able to identify the lymphatic leak and eventual anatomic aberrations and allows a tailored and effective surgery.

Reference


The authors of the original paper [1] were invited to reply to this Letter to the Editor but they did not respond.

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Letter to the Editor

Coronary artery imaging with 64-slice computed tomography from cardiac surgical perspective

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