of VATS lobectomy compared to thoracotomy lobectomy and the influence of the length of stay very much mirror our own larger experience in Canada. When we compared costs of over 250 VATS lobectomy cases to an open lobectomy, intra-operative costs were approximately double ($2810CD vs $1425CD). However, length of stay (LOS) was 1.3 days shorter for VATS cases (4.9 days vs 6.2 days). Based on an analysis of overall costs, a VATS lobectomy was equal or slightly less than an open lobectomy ($8573CD vs $8673CD). The similarity between the costs from our experience and that of Mr Walker’s group is striking.

An additional influence on intra-operative cost and potential impact on LOS is the need to convert a VATS to an open lobectomy. No mention was made of this, though elsewhere the group has reported conversion rates of around 10% [2]. In our analysis, conversion rates over the 3-year period were 13% (35 cases converted). We have examined the causes of conversion in our unit and proposed a method of auditing this (presented recently as an abstract at the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) 2009 meeting). Clearly, the timing and cause of conversion during surgery will have some influence on the intra-operative costs incurred, but, overall, converting a VATS lobectomy to a thoracotomy had little impact on total intra-operative costs ($2861CD no conversion vs $2569CD converted). The difference between LOS on patients who had been converted was half a day (4.9 days no conversion vs 5.4 days converted). Majority of the patients were converted through an extension of the axillary utility incision with only a few patients requiring a separate posterolateral thoracotomy. This translated into a difference in LOS costs of $610CD ($5669CD no conversion vs $6279CD converted). Overall the difference in costs incurred following conversion was $303CD ($8546CD no conversion vs $8849CD conversion).

Conversion through the axillary incision appears to have a small adverse influence on increased LOS and overall impact on cost was low. Our experience will be presented this summer at the 13th World Conference on Lung Cancer, and we welcome Mr Walker’s perspective on the influence of conversion rates on the costs incurred.

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* Corresponding author. Tel.: +1 780 735 5981; fax: +1 780 735 4245. E-mail address: Eric.Bedard@Capital.Health.ca (E.L.R. Bédard).

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Reply to the Letter to the Editor

Reply to Hunt et al.

Gianluca Casali *, William S. Walker
Cardiothoracic Surgery Department, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh EH1 4SA, UK

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Keywords: Lung cancer; Lung resection; VATS; Cost-effectiveness; Minimally invasive surgery; Thoracotomy

We thank Dr Hunt and colleagues for their letter [1] and thoughtful remarks.

The case volume reported in our study [2] is a limited contemporary proportion of early-stage cases extracted from our video-assisted thoracoscopic surgery (VATS) series and compared with uncomplicated open-matched case controls. We used this strategy in an attempt to provide contemporary and homogeneous costing for the study and comparator groups.

We did not include converted cases and Dr Hunt and colleagues are correct in their observation. Our intellectual rationale for this choice was based on several considerations. First, we felt that open lobectomy represented the default choice and that conversion was less a consequence of technique than of the situation encountered during the operative procedure. As converted patients represented a relatively small proportion of VATS cases, we considered that they would not represent a significant confounding factor. Moreover, not all open cases go smoothly — the open equivalent of conversion, perhaps — in which event, cost for these cases will also escalate.

However, if we had adopted an intention-to-treat strategy and used a worst-case proposition for converted cases, these would have attracted the full VATS theatre cost and the Open hospital stay cost. Thus, eight additional converted VATS cases would have contributed a further 1407 Euros per case representing an added cost of 139 Euros per case for the VATS group overall, which would still leave the VATS cases fractionally less expensive. In fact, the case presented is that a VATS strategy is no more expensive, has many well-documented patient advantages and does reduce bed stay to the benefit of the host institution.

It is extremely encouraging that, in another continent and altogether different health-care system, Dr Hunt and colleagues have determined similar findings to ours regarding the comparative costs of open and VATS lobectomy. The implications regarding data consistency are clear. We look forward to the publication of their data, which will clearly be a further valuable addition to the weight of evidence in favour of VATS resection.

References

Letter to the Editor

Problem with 'A review of 24 patients with bronchial ruptures: is delay in diagnosis more common in children?'

Erkan Yildirim*
Ankara Ataturk Chest Diseases and Chest Surgery Center, Division of Chest Surgery, Ankara, Turkey

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Keywords: Intellectual property; Specialty thesis; Dispute

I read the article regarding bronchial ruptures published in EJCTS in March 2003 with great interest [1]. To note, the published article astonishingly overlaps with the same patient group and fails to either cite or acknowledge the thesis titled "Tracheobronchial Ruptures in Blunt Chest Trauma", written in 1998 by Yildirim E. [2].

The specialty thesis regarding 21 patients with tracheobronchial ruptures was written 5 years before the article (including 24 patients with the same injury) was published in 2003.

In the thesis, the same group of patients was evaluated as a whole and the outcomes were given in many tables regarding diagnostic tools, treatment options, surgical techniques, hospital stay, complications, etc.

On the other hand, the article has divided the same group of patients into two major groups (<15 years vs >15 years) and then has presented the results comparing the two groups.

The only major difference was the three patients with bronchial injury who were allocated additionally into the study group between 1998 and 2003.

It seems the article is based to a great extent on the same patients included in the specialty thesis.

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* Corresponding author. Address: D Level North Wing, Mailpoint 46, Southampton General Hospital, Tremuna Road, Southampton, SO16 6YD, UK.
Tel.: +44 23 8079 5935/5911; fax: +44 23 8079 4526.
E-mail address: gianlucasali@yahoo.com (G. Casali).
doi:10.1016/j.ejcts.2009.07.036

Reply to Letter to the Editor

Reply to Yildirim

Ali Özdülger*
University of Mersin, School of Medicine, Department of Thoracic Surgery, Mersin, Turkey

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Keywords: Unfair accusation; Major intellectual difference; Children

Atatürk Center for Chest Diseases and Thoracic Surgery, where I was employed as co-consulting surgeon of a surgical team, is an old institution in Ankara, Turkey. Naturally, large series of different entities related to thoracic surgery have been recorded over more than 40 years.

Among these entities, the topic 'Traumatic Tracheobronchial Ruptures (TTBR)' has always attracted special attention. Likewise, Dr Cetin, chief of the surgery division, had already published them twice in 1974 and 1984, which have been cited as the eight and ninth references in the thesis of Yildirim [1].

In 1992, Dr Cetin entrusted me the responsibility of continuing to collect the data of patients with TTBR treated in our institution and publishing them on a regular basis.

In 1995, 3 years before the thesis of Yildirim was written, I and a group of authors presented on this topic at the 23rd National Congress of Turkish Association of Respiratory Research held between 11 and 14 June 1995 at the Hilton Convention Center, Istanbul, Turkey [2]. This was the third publication of the TTBR series before the thesis was written.

In 1998, Yildirim wrote his graduating thesis largely based upon this regularly updated data and documents on TTBR. Therefore, there was an overlap in patient groups for the first time in 1998 because the thesis largely drew from the patient groups mentioned in our presentation in 1995.

Later, we presented the same details but updated the patient groups yet again at the World Congress on Lung Health and 10th ERS Annual Congress held between 30 August and 3 September, 2000, in Florence, Italy [3]. Neither the first nor the second presentation has been the subject of any claim of intellectual property yet.

Lastly, the same but re-updated patient groups of TTBR was published in this journal in 2003 [4], where I studied the topic from a different perspective definitely not comparable either to our previous publications or to the thesis.

Naturally, I used our own regularly updated original database instead of an old-fashioned copy from 1998.