Letter to the Editor

Open versus thoracoscopic thymectomy for non-neoplastic myasthenic patients: is there a space for a third way?

Giacomo Cusumano a, *, Alfredo Cesario a, b, Stefano Margaritora a, Pierluigi Granone a
 a Division of Thoracic Surgery, Catholic University Rome, Rome, Italy
 b Scientific Direction, IRCCS San Raffaele Pisana, Rome, Italy

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We have read with great interest the article by Lin and colleagues [1] reporting on the outcome of the comparison between minimally invasive video-assisted and open-extended trans-sternal approaches for thymectomy in patients affected by myasthenia gravis (MG).

The discussion regarding the optimal surgical approach for thymectomy in MG is an ongoing widely debated issue. Substantially, the lack of a univocal and validated parameter to challenge the appropriateness of any given approach is based on the fact that the long-term remission remains somewhat not directly, consistently and coherently connected with the extension of the resection performed during thymectomy [2]. Nevertheless, a commonly shared opinion remains that the thymus along with any possible extra-thymic tissue should be removed at the time of operation and this belief gives strength to the assessment of any given approach, which is commonly based on the overall amount of thymic tissue and mediastinal fat removed during operation [2,3]. In this setting, again, the degree of uncertainty is witnessed by the lack of any validated ‘cut-off’ quantity. Following the lines of extreme simplification and briefly integrating the data reported by Lin [1], we could speculate that an approach which gives both the best exposure of the mediastinum and an ideally low to very low morbidity rate would meet all the requirements needed for an MG patient where surgery has been indicated. The cosmetic outcome could have its relatively high value, especially in young women. Our group has rich experience in thymectomy for MG patients and we have adopted, in this setting, an original approach for thymectomy with a video-assisted infra-mammary cosmetic incision and median sternotomy, originally described in 1999 and, to date, used in more than 180 cases with clinical results perfectly in line with the benchmark for the population in study and optimal cosmetic outcome [4]. Through a 5 ± 6 cm curvilinear incision at the median infra-mammary line we create a subcutaneous flap to perform a complete median sternotomy. The upper mediastinum and the lower neck regions can be well examined and a perfect control on the brachiocephalic and superior vena cava is possible with the aid of video-thoracoscope, introduced through the same incision. With this procedure we have a clear vision of the entire thymus, pericardium and adipose tissue along both phrenic nerves and the dissection can be performed with safety.

Indeed, the use of the video-assisted technique avoids potential dangers associated with transcervical thymectomy such as the crowding of instruments into a narrow access incision and restricted viewing of the operative field. A video of the operation can be seen at www.rm.unicatt.it/timectomia.

Herein we would kindly invite the authors to discuss our approach at the light of their experience: it seems, in fact, that our approach perfectly matches with the ‘pros’ of both a median sternotomy and a video-assisted approach and appears among the validated techniques as cited by Sonett and Jaretzky [5].

References


* Corresponding author. Address: Catholic University — Policlinico Gemelli, Largo F.Vito 1, 00168 Rome, Italy. Tel.: +39 0 6356353.
E-mail address: giacomare55@hotmail.com (G. Cusumano).

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Reply to Letter to the Editor

Reply to Cusumano et al. Open versus thoracoscopic thymectomy for non-neoplastic myasthenia gravis: a rejoinder

Mong-Wei Lin a, Yih-Leong Chang b, Pei-Ming Huang a, Yung-Chie Lee a, *
 a Department of Surgery, National Taiwan University Hospital and National Taiwan University College of Medicine, Taipei, Taiwan
 b Department of Pathology, National Taiwan University Hospital and National Taiwan University College of Medicine, Taipei, Taiwan

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We appreciate the observations and insights raised by Cusumano and co-workers [1] regarding our study on thymectomy for non-thymomatous myasthenia gravis (NTMG) [2].

We agree that the standard surgical approach for NTMG remains controversial. The goal of thymectomy in MG patients is to achieve the best complete stable remission (CSR) rate, which is related to the radical removal of thymic tissue [3]. Many different thymectomies can achieve this, including trans-cervical, trans-sternal and thoracoscopic.