We read with interest the small but elegant cadaveric anatomy study by Hu et al. [1] comparing the lengths of the anterior with the posterior mediastinal routes for oesophageal reconstruction. The ideal route of reconstruction has been a longstanding controversy in oesophageal surgery, with several randomized trials and even a meta-analysis [2] on the subject. The meta-analysis did not show statistically significant differences in complication rates and outcomes between the anterior and posterior mediastinal routes but admitted that there was a need for more data. Hu et al. conclude that, contrary to the popular belief, the anterior mediastinal route is significantly shorter than the posterior route. This cadaveric study supports the results of the same group's intraoperative study [3] published earlier but contradicts other cadaveric studies [4, 5]. The authors base their measurements on different distal points than those used routinely in previous studies. We agree with the authors that the distal reference points they used are certainly more clinically relevant than the coeliac axis.

The choice of reconstruction route for most of the surgeons would depend on various factors, namely the anticipated risk of local recurrence, potential need for postoperative radiotherapy for a R+ resection, whether the surgery was done after oesophagectomy or just as a bypass procedure with the oesophagus in situ, past history of sternotomy, personal choice and importantly, the length to be traversed by the gastric substitute. Our standard preference so far has been to use the posterior mediastinal route in all cases unless we anticipated a high risk of local recurrence or planned postoperative radiotherapy (~10% of patients). Major postoperative complication rates in 820 patients who underwent posterior mediastinal reconstruction were similar to 97 patients who underwent an anterior reconstruction (25.5 versus 27.1%, P > 0.05) over the past eight years. One of the potential advantages of using the anterior mediastinal route could be a lower incidence of septic mediastinitis in the case of anastomotic leaks. This has been an unconfirmed observation in our series and we are interested to know the experiences of the authors and other oesophageal surgeons in this area. If that were so, the authors’ results could then provide a powerful argument for routinely using the anterior mediastinal route for oesophageal reconstruction. We intend to measure the required length through both routes intraoperatively in our patients and urge other oesophageal surgeons to generate unequivocal data on this issue.

REFERENCES