LETTER TO THE EDITOR

Video-assisted thoracic surgery is effective in systemic lymph node dissection†

Alessandro Baisia, Alessandro Rizzi, Federico Ravellia and Ugo Cioffib,*

a Thoracic Surgery Unit, Azienda Ospedaliera San Paolo, University of Milan, Milano, Italy
b Department of Surgery, Fondazione IRCCS Ca’ Granda Ospedale Maggiore Policlinico, University of Milan, Milano, Italy
† Corresponding author. Department of Surgery, Fondazione IRCCS Ca’ Granda Ospedale Maggiore Policlinico, Via F. Sforza 35, 20122 Milano, Italy.
Tel: +39-02-55035568; fax: +39-02-55034165; e-mail: ugo.cioffi@policlinico.mi.it (U. Cioffi).

Received 14 February 2013; accepted 3 April 2013

Keywords: Video-assisted surgery lobectomy · Systemic lymph node dissection · Mediastinal staging · Lung cancer

We read with interest the study by Palade et al. [1]. Their objective was to evaluate the possibility of achieving a nodal dissection by video-assisted surgery (VATS) as effectively as by open surgery.

The background of the study is based on the European Society of Thoracic Surgeons 2006 guidelines [2] that recommend intraoperative systemic lymph node dissection for every surgically treated non-small-cell lung cancer (NSCLC). We agree with these indications, which are accepted by most authors; however, some others have recently reported interesting data supporting the possibility of performing a less-invasive nodal sampling in early-stage cases. Zhang et al. [3] have reported that, in T1aN0M0 patients, the number of nodal stations dissected and Station 7 dissection were both not statistically significant factors in determining prognosis. Moreover, Tsutani et al. [4] have reported the experience of a multicentre database showing that tumour size <0.8 cm and SUVmax <1.5 were significant predictive criteria of negative nodes, and concluded that in these cases, systemic lymphadenectomy for clinical Stage IA lung adenocarcinoma may be avoided, even in cases of T1b (2–3 cm) tumours. A question for the future is whether the necessity of a systemic lymph node dissection in early-stage NSCLC may become a topic for discussion again.

Concerning the results of the authors, it should be underline that both the number of the overall nodes and of those for each zone removed were equivalent in VATS and open procedures. It is also very remarkable that postoperative outcomes were significantly in favour of VATS. These results are consistent with data related to the oncological efficacy of VATS lobectomy compared with open lobectomy [5] and encourage a further increase in the procedures performed.

Among the variables considered by the authors, only the mean intraoperative time was in favour of open surgery, with an advantage of half an hour. This was probably due to the difficult exposure of some anatomical regions like the subcarinal one.

Palade’s study confirms our opinion on thoracoscopic lymphadenectomy. According to our experience, we think that, except for 4L, every nodal station can be reached and dissected by a thoracoscopic approach. Therefore, we assume that the efficacy of this technique is mostly related to the operating surgeon. Since the lack due to the learning curve in thoracoscopic surgery can be easily managed with an accurate training, it does not represent an absolute contraindication to VATS lymphadenectomy.

Moreover, VATS may proffer many advantages in the hands of a surgeon skilled in thoracoscopy; the most interesting being that the camera presents an excellent visualization of the anatomical structures once correctly exposed.

Concerning surgical technique, we agree with the authors who suggest the use of the harmonic scalpel, since this instrument was safe and successful in avoiding bleeding and lymphatic loss in our experience also.

We conclude by congratulating Palade et al. on their prospective randomized trial.

REFERENCES