Con the best surgical procedure in such “benign” neoplasms. A comparison between both groups.

ure of the tumour pedicle (usually shadowed) and more vascular supplies. For this inherently and strongly associated with a more dif

confounding selection bias: in fact, as reported by others [4], bigger solid tumours are statistically in pathological tumour size. In our opinion, this difference translates in a terms of clinical (age, gender, side) and pathological (histology) features, they differed

tended hospital stay in the VATS group. Though both groups were comparable in

reported a diminished intraoperative blood loss, reduced operative time and shor-
ingly thoracotomy (Group A) and 19 receiving a VATS resection (Group B) and

As a rule, the incidence of mediastinal tumours is low, and tumours from posterior are generally benign, all efforts should be directed towards their surgical resec-

tion with minimally-invasive approaches, even when they arise as multiple simul-

In this setting, the Authors [1] performed a comparative analysis on 44 patients

Accepted opinion today that benign intrathoracic neurogenic tumours smaller than 6 cm in size are good candidates for video-assisted thoracoscopic surgery resection, which can be achieved safely with rapid recovery [3, 4]. When the tumour exceeds 6 cm in size and is located at a costophrenic angle or at the thoracic apex, the real dilemma of choosing the most appropriate surgical approach arises.

In the last 5 years at our department, we have surgically treated two male patients in their early thirties, with palpable masses with an ulnar distribution in the left supraclavicular region, paraesthesia and loss of strength in the left hand. Computed tomography scans revealed a smooth, round tumour of more than 9 cm in diam-

eter. In both cases, a left supraclavicular approach was undertaken. A supraclavicular incision permitted an accurate and safe exposure of the cervical portion of the tumour and its mobilization from the superior and median trunk of the brachial plexus close to the upper border of the first rib. The tumour was enucleated and shelled out of the lower trunk, avoiding any injury to the trunk itself. Pleural cover and remnants of the capsule at the root of neck were easily cleared. Histology of the tumours established the diagnosis of schwannoma. Twelve months after surgery, there were no residual numbness, paraesthesia and loss of strength of the left arm in both patients.

In conclusion, considering that neurogenic tumours arising at the thoracic apex are generally benign, all efforts should be directed towards their surgical resec-
tion with minimally-invasive approaches, even when they arise as multiple simulta-

taneous lesions or in unusual locations. For those lesions extending in the cervical region that do not involve the spinal canal, a multidisciplinary team including thoracic and vascular surgeons allows their resection in a safe single-stage procedure.

Conflict of interest: none declared.

References


eComment. The supraclavicular approach for removal of neurogenic tumours at the thoracic apex

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The Shanghai group [1] presented a cohort of 63 surgically treated patients who were operated on during a time period of 20 years. Not so long ago, similar results were presented by the Osaka group [2]. Both groups of authors agree that it is an accepted opinion today that benign intrathoracic neurogenic tumours smaller than 6 cm in size are good candidates for video-assisted thoracoscopic surgery resection, which can be achieved safely with rapid recovery [3, 4]. When the tumour exceeds 6 cm in size and is located at a costophrenic angle or at the thoracic apex, the real dilemma of choosing the most appropriate surgical approach arises.

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