Minimally Invasive Technique for Bronchoplastic Procedure

To the Editor:

We read with great interest the recent article on minimally invasive techniques by Santambrogio and colleagues (February 2002). They reported the case of a young female patient with a bronchial mucoepidermoid carcinoma who was successfully treated by a video-assisted sleeve lobectomy.

Video-assisted thoracoscopy (VAT) has increased interest in using this minimally invasive approach for many thoracic surgical procedures. In fact, it is commonly considered to be an effective and less invasive modality for the management of benign and malignant pulmonary and pleural diseases and for the repair of bronchial defects in some cases, allowing shorter convalescence and hospitalization, lower morbidity and mortality, and lower overall cost.

The originality of the technique of Santambrogio et al is the accomplishment of a sleeve lobectomy through a very small “utility thoracotomy” using thoracoscopic guidance. For an accurate interpretation of their technique and results, it would be important to know the intervention time, whether the procedure was completed using conventional or thoracoscopic surgical instruments, whether an extended lymphadenectomy was carried out, and, finally, whether there were perioperative complications.

In our opinion, in properly selected patients and for surgeons with VAT skills, this operative procedure could become a valid therapeutic option for the treatment of patients with benign and malignant pulmonary and pleural diseases and for the repair of bronchial defects in some cases. However, the advantages of VATS include minimized pain, better cosmetic results, a shorter hospital stay, and fewer complications.

In our case, the surgical time was 5 h. The procedure was performed using both standard thoracoscopic and conventional surgical instruments. Through the utility thoracotomy, we used an anatomic forcesp for the exact holding of the bronchial and hilar structures, and Duval forces to distend the lung parenchyma and to facilitate the surgical knots.

An accurate and extended lymphadenectomy of all mediastinal, hilar, interlobar, and paraesophageal nodes was carried out. We reported neither perioperative nor postoperative complications.

We believe that the indications for VATS in the hands of experienced surgeons may be more widespread than previously anticipated.

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REFERENCES