LETTER TO THE EDITOR

Author's Response to an Unusual Presentation of Spontaneous Chylothorax

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Response

We thank you for reading our case report with great interest and for the keen observations made. We will try our best to address the queries raised after the observations.

The aim of the case report was to highlight the rare clinical presentation and course of spontaneous bilateral chylothorax with unknown etiology. Also, managing spontaneous chylothorax presents a dilemma with regard to the best course of treatment and hence needs to be individualized as the literature suggests.[1] Multiple review articles present varied timelines of treatment modalities of chylothorax.[2–4]

We appreciate the well-read clinicians in bringing out very important observations. Since the table could be very extensive and unsuitable for this genre of publication with all readings, we preferred to share total drain output at time points of blood investigation only (absolute lymphocytic counts and total protein).

We agree that octreotide should have an early consideration in the management of chylous pleural effusion. In our case, the child responded very well to conservative management of dietary management causing total drain output to reach zero. Total drain output remained zero before surging up. In a systematic review, the median duration of treatment with octreotide was 22 days (range: 3–151), which is variable given that there was a recurrence of chylothorax in our case. An octreotide treatment trial could have meant a prolonged hospital stay with a probable failure rate of approximately 20% and a risk of hospital-acquired infections.[2] Thus, our team of clinicians agreed that pleurodesis is the rational choice after a fair trial of conservative management.

We understand that prolonged continuous fluid drainage leads to malnutrition and infections. But in our case, since conservative management was successful initially, we thought it would be prudent to wait for surgical intervention since it involves its own risks and morbidities. Also, without a clear etiology despite an extensive evaluation, it is difficult to delineate the threshold for surgery. As per data, there need for surgery in 23% of cases only and the reported timing of surgery is variable, 39 days (range 11–150 days, data from 41 cases), owing to different nature of the presentation, course, and response to treatment.[2]

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As already mentioned, such children need to be followed up for prompt detection of possible malignancy.

We would like to thank readers for bringing out very relevant points of discussion and conclude the need for a systematic review of chylothorax treatment modalities on available data in the pediatric age group to aid future management of chylothorax.

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