



MORE DETAILS OF SURGICAL TECHNIQUE NECESSARY



To the Editor:

I read with interest the article “Empiric Flap Coverage for the Pneumonectomy Stump: How Protective Is It? A Single-Institution Cohort Study,”

by Steimer and colleagues.¹ The authors presented their institutional results regarding the rate of postpneumonectomy bronchopleural fistula (BF) in terms of possible protection of the bronchial stump with vascularized flaps. In general, the rate of 10.6% of BF reported in the article is quite high.

I would like to raise some points regarding the article. The analysis of the results almost completely avoided any technical details of management of the bronchial stump and dissection of the various types of flaps. In my opinion, the lack of these technical details is a serious drawback of the study. There are several technical issues that should be clarified. For example, why was the closure of the bronchial stump performed with the use of a stapler in all patients? According to the literature, there is no evidence that the use of a stapler for closure of the bronchial stump is better than manual closure techniques in terms of BF rate. There are several publications presenting the techniques of the manual suture bronchial stump closure reporting lower BF rates than 10.6% in Steimer and colleagues’ study.¹ These techniques have been described by other authors.²⁻⁴ The use of staplers is especially disputable in case of patients undergoing previous neoadjuvant chemotherapy or chemoradiotherapy when the bronchial wall may be thickened and may heal worse than in patients without neoadjuvant chemotherapy. The rates of postpneumonectomy BF should be at least discussed in the article.

The other technical points that were omitted in the article regard the technique of dissection of the various flaps, its transfer to the stump area, and techniques of securing the flap to the bronchial stump. It would be valuable to know how these operative steps were done. Why did the flaps fail to protect the stump—because of ischemic necrosis or for the other reasons?

Which flaps were used preferentially and how a thoracoplasty (or maybe thoracomyoplasty) was performed in patients in whom a BF was discovered after a tube drainage and an open window thoracostomy (“the Claggett window” is not a proper term⁵)?

In summary, I have some general remarks. In many recent articles, the technical details of operative procedures are regarded as something of secondary importance, in comparison with the other parts of analysis, or are avoided, as in the article by Steimer and colleagues.¹

However, for traditionally oriented thoracic surgeons, the operative technique is still the most important part of our profession. Unfortunately, many surgeons’ failures are the result of the ways the operations are performed.

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Conflict of Interest Statement

The author reported no conflicts of interest.

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