



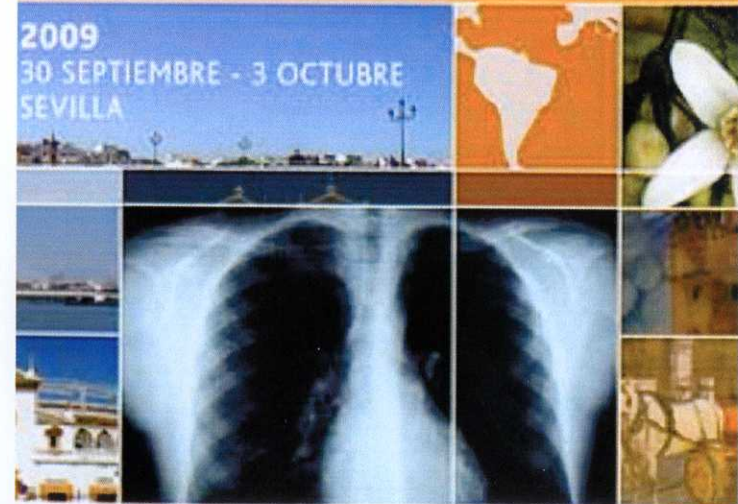
MCL ED.
SEVILLA



Programa Final

XVII CONGRESO
DE LA ASOCIACIÓN IBEROAMERICANA
DE CIRUGÍA TORÁCICA
"MEMORIAL JAVIER AYARRA"

2009
30 SEPTIEMBRE - 3 OCTUBRE
SEVILLA





Surgical treatment of benign tracheoesophageal fistulas with tracheal resection and Esophageal Primary Closure: Is the Muscle Flap Really Necessary?.

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P76 T. N. Machuca, J.J. Camargo, S.M. Camargo, S.M. Schio, J.C. Felicetti, C. Costa Oliveira, V. Lobato, F.A. Perin. Thoracic Surgery Service and Lung Transplantation. Complexo Hospitalario Santa Casa De Porto Alegre. Brasil **Surgical treatment of bronchial complications following lung transplantation.**

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CONFERENCIAS MAGISTRALES

VATS. STATE OF THE ART AND PERSONAL EXPERIENCE

Giancarlo Roviato MD FACS, Contardo Vergani MD FACS, Luca Despini MD

In terms of watersheds in the history of surgery, the 20th century will be remembered for the advent and rapid diffusion of minimally invasive techniques. Following fast on the first laparoscopic cholecystectomy in 1987, we have witnessed a veritable explosion in endoscopic surgery. No other surgical technique has received such widespread approval in so little time. The rapid improvement in endoscopic materials and techniques has also fostered the development of modern thoracoscopic surgery.

The origins of thoracoscopic surgery can be traced to the beginning of the 20th century. In the early 1900s, the Italian Forlanini devised a technique for the creation of an artificial pneumothorax to collapse and heal tuberculous cavities, but adhesions between the



lung and the chest wall frequently prevented the establishment of an adequate pneumothorax. To overcome this limitation, in 1910 Jacobaeus, a Swedish professor of internal medicine introduced a rigid cystoscope within the pleural cavity for the first time, with the purpose of dividing the adhesions and allowing the lung to collapse. The combined techniques of artificial pneumothorax and thoracoscopy were widely employed for the treatment of tuberculosis during the presurgical period and throughout the 1950s. The enthusiasm for this thoracoscopic approach ended in 1945 with the introduction of streptomycin, which ushered in a period of neglect for thoracoscopy.

In 1972, the first edition of Shield's General Thoracic Surgery included only a few lines on this technique, concluding "currently however, indications for thoracoscopy are encountered only rarely". In 1978, Bloomberg stated that "while some older surgical techniques are still being used, there are some that have been completely forgotten one of these is thoracoscopy". At the end of the 1980s, however, the



development of advanced optics, miniaturized cameras, and automatic endoscopic stapling devices opened up new opportunities in this area, thereby inaugurating the era of modern thoracoscopic surgery. Thoracoscopic surgery now represents a valid alternative for all diseases in which a thoracotomy incision seems disproportionate for carrying out a relatively simple operative procedure. At many centers, thoracoscopy is now considered the approach of choice for diagnostic procedures, large pulmonary biopsies, the treatment of pneumothorax, wedge resections, bullectomies, and other diseases that can be treated via non anatomic pulmonary resection.

Other, more serious procedures such as lung volume reduction surgery (LVRS) for emphysema, mediastinal tumor resections, and the staging and treatment of lung cancer have not met with a similar acceptance and are still only performed at selected centers, often using widely different techniques.

Patients and methods



Between June 1991 and December 2008, 9112 minimally invasive procedures were carried out in our general surgery department. There were 5849 laparoscopic and 3263 thoracoscopic procedures. Our experience includes thoracoscopic procedures for the staging of lung cancer (n=1377), wedge resections (n=564), major pulmonary resections (n=380), diseases of the pleura (n=252), spontaneous pneumothorax (n=251), mediastinal diseases (n=172), giant bullae and emphysema (n=122), esophageal diseases (n=29), and a number of miscellaneous procedures (n=116).

Discussion

The first international symposium devoted to thoracoscopic surgery was held in San Antonio, TX, USA, in January 1993. On that occasion, an overview was given of the different techniques that had been developed over the preceding 3 or 4 years. It was immediately apparent that certain kinds of videothoracoscopic procedures were easy to learn and to perform, whereas others were technically complex



and required a considerable learning phase. This impression was confirmed in practice over the following years. The more simple procedures rapidly became gold standard treatments, while the more complex ones have yet to find a precise standing; the indications and operative techniques also vary considerably among different authors.

Conclusions

Although 10 years have passed since its introduction, modern videothoracoscopic surgery is still far from achieving the scientific and operational maturity attained by laparoscopy. In spite of the obvious advantages characteristic of minimally invasive surgery, including less postoperative pain, a shorter hospital stay, and better cosmetic results, the acceptance of this modern approach to thoracic disease is still being staunchly resisted and opposed by many conventional thoracic surgeons. There are multiple factors at the root of this opposition, most decisively the lack of adequate, specifically designed instrumentation and the fear of intraoperative



accidents that will be extremely difficult to handle and resolve successfully.

In the case of malignant diseases, the lack of definitive and long-term results does not allow any conclusions to be drawn about the advantages of videoendoscopic techniques vs conventional surgery, and many oncological concerns have been raised. Moreover, the techniques have not been universally standardized and series are limited. Even though the preliminary results from different authors appear to indicate better results than those achieved with conventional surgery, this is not enough to justify the extensive adoption of these procedures.

In the last few years, however, the possibility that thoracoscopic techniques can be used in the treatment of diseases for which a sternotomy or thoracotomy access would appear disproportionate (i.e. wedge resections, the treatment of pneumothorax, LVRS, sympathectomy, etc.) with a success equivalent to that achieved with conventional surgery, has been definitively confirmed. We can therefore be hopeful



that videothoracoscopic techniques will eventually overcome their current limits and obstacles and find general and widespread application.