

Anterior Thoracoscopic Subcarinal Nodal Dissection: A Better Approach?

To the Editor:

We have read with interest the paper by Baste and colleagues [1] describing an anterior technique to dissect subcarinal nodes after left-sided video-assisted thoracic surgery (VATS) lobectomy. The main points of their paper are the following: (1) complete nodal dissection is recommended even in early staged non-small cell lung cancer (NSCLC), to guarantee the most accurate staging; and (2) to be accepted, VATS lung resection should allow the same nodal dissection as open thoracotomy.

One of advantages of VATS is surely the better exposure of anatomic structures as a result of a closer view. Some authors have even found that, in skilled hands, VATS guarantees a larger number of dissected lymph nodes [2]. However, many surgeons still argue that thoracoscopic dissection, especially on the left side, is less accurate because of the anatomic and technical difficulties.

The authors describe their experience with the anterior approach to subcarinal nodes. According to the paper, this technique is successful. However, few data about complications, number of nodes dissected, and type of dissection are reported, and they do not statistically compare this technique with the posterior approach.

Theoretically, adopting the standardized three-port Copenhagen approach [3], the approach of Baste and coworkers to subcarinal nodes should have an advantage because the anterior position of the camera port provides a better anatomic field of view. Moreover, without any anterior traction of the lung to expose the subcarinal space, parenchymal damage and air leakage should be avoidable.

Our only concern is that bronchus grabbing is often needed to lift up the airways, and this step could damage the stump. However, as the authors assure, this approach should also reduce any damage to the bronchial microvasculature that could potentially cause bronchial necrosis and bronchopleural fistula. Another concern is that, with this technique, nodal dissection is always made at the end of the lobectomy when the anterior hilar structures have already been dissected. Sometimes, nodal biopsy must be performed before lobectomy is begun.

To conclude, we congratulate the authors because their technique can surely be useful to those who are interested in thoracoscopic surgery.

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Reply

To the Editor:

We have read the comments and questions raised by Alessandro Baisi and colleagues [1] and thank these authors for the interest they show in our technique of anterior subcarinal node dissection by video-assisted thoracoscopy. We sincerely hope that the answers we provide will shed light on the matter and further advance the knowledge.

Indeed, to expose the subcarinal area we either grab the stump firmly or, preferably, lift the main bronchus with an instrument. We do this using extreme caution [2]. We have performed almost 400 video-assisted thoracoscopic lobectomies but have seen only 1 bronchial fistula, which was in fact on the right side and not on the left side. Although our overall fistula rate is officially 0.25%, it is in fact 0% on the left side. Thus our rate compares most favorably with the 3.4% rate reported in the literature for lobectomy on the left side [3].

Our anterior technique achieves complete dissection of the subcarinal area [2, 4] and follows the anatomical landmarks. Our aim was to report our anterior technique to share the knowledge. We did not wish to compare anterior dissection and posterior dissection of the subcarinal space.

Once again, we sincerely thank the Milan team for the interest it has shown in our anterior technique and especially in video-assisted thoracoscopy.

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