Letter to the Editor

The advantage of sleeve lobectomy over pneumonectomy

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Response to: Ludwig C. Editorial comment on "Reimplantation of the upper lobe bronchus after lower sleeve lobectomy or bilobectomy: long-term results" by Maurizi et al. J Thorac Dis 2018;10:6427-9.

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The comment from Dr. Ludwig (1) to ore recent paper on lower sleeve lobectomy, the so-called "Y" sleeve (2), is interesting and it deals on some important points related to technical aspects in this setting. It is a pleasure to reply to an author that has published important contributions on sleeve lobectomy, reporting, over time, results from patients that had undergone sleeve lobectomy and pneumonectomy. Our experience is in line with other experiences like that of Dr. Ludwig and colleague (3). We strongly believe in the dramatic importance represented by offering, when technically and mainly oncologically feasible, bronchovascular reconstructive procedures in order to avoid pneumonectomy for the resection of centrally located lung cancer. In her letter, Dr. Ludwig recalls the advantage of sleeve lobectomy over pneumonectomy in term of postoperative mortality and morbidity as showed by the published series (3-7).

Dr. Ludwig comments on different suturing techniques used to perform bronchial anastomosis. Even though, all of us have seen and red about good short- and long-term results after running suture, our preference for an interrupted suture (complete or partial with running sutures on mediastinal portion of the anastomosis) is mainly due to correct potential calibre discrepancy between the bronchial stamps. Moreover, tying the stiches after they all have been placed interruptedly can help the reconstructive surgeon in achieving a uniformly distributed tension-free anastomosis (5,6).

Regarding the concern expressed by the latter author about the use of a viable tissue flap (intercostal muscle) to cover and to protect the bronchial anastomosis, we have frequently reported that, in our experience, it should be mandatory in case of combined bronchovascular reconstruction, and that it is highly recommended in case of complex bronchoplasty; even more if after neoadjuvant therapy (5-8).

In response to the last comment of Dr. Ludwig, we are aware of the limitations of our study, in particular the small number of patients included over a long study period, retrospectively evaluated; however our study was the first focusing on a homogeneous sample of patients that underwent only lower sleeve lobectomy performed by the same technique and by the same surgical team.

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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