Circumferential Tracheal Replacement: Do the Benefits Warrant the Risks?

To the Editor:

Fabre and colleagues [1] recently reported their experience of both lateral and circumferential tracheal repair with special reference to the already described use of cartilage-reinforced forearm free flaps [2]. Of 12 patients, 2 underwent lateral repair of esophagotracheal fistula, 4 salvage operations, and 6 tracheal/carinal replacement for adenoid cystic carcinoma (ACC) (n = 5) or malacia (n = 1). Although flap-wrapped aortic allografts have proved useful in elective central airway replacement [3], and recently in the emergency setting [4], Fabre and colleagues claim that “we believe this technique, with a mortality of about 50%, should not be used.” Therefore, we take the opportunity to briefly compare the patient data of their six tracheal/carinal replacements with the data from our study [3] (enrollment from 2005 to 2007) of 6 patients undergoing tracheal resection involving the carinal region in four cases, followed by repair with aortic allografts, for ACC (n = 5) or mucoepidermoid tumor (n = 1): (1) In-hospital mortality, 2/6 versus zero; (2) pathology (ACC patients), 4/5 R1 resection versus 5/5 R0 resection; (3) mean survival time, 25 months versus 64 months (of our 6 patients, 3 died at 26, 45, and 77 months, and the 3 survivors at 72, 76, and 87 months are currently in full-time employment). According to the 100% efficacy of chemoradiation in locally advanced ACC of the trachea reported by Allen and colleagues [5] and recently confirmed through electronic communication with the authors, we decided, however, not to include further patients in our study. The results of Fabre and colleagues reporting severe mortality and morbidity (mainly adult respiratory distress syndrome and arterial rupture), and poor quality of life (mucus plugging and 66% of definitive tracheostomy) after implantation of their neoconduit also pleads in favor of chemoradiation as an alternative therapy. By contrast, the successes obtained in esophagotracheal fistula operations demonstrate the relevance of fasciocutaneous flaps in the setting of lateral tracheal repair [1].

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References

Have Robots a Future in Sympathetic Operations?

To the Editor:

We read with interest the articles by Coveliers and colleagues [1, 2], and we compliment the authors for their important study of video-assisted thoracic sympathectomy (VATS) ablation for primary palmar hyperhidrosis. The major innovation in their technique is the use of a robot to perform the procedure. Their type of ablation (efferent ramification) is not new, but their results at medium-term follow up are encouraging. However, we question the use of a robot for the following reasons: it is an expensive instrument with limited availability in the majority of hospitals, even in countries with very advanced medical facilities. The technique requires four incisions (3 of 2 cm and 1 of 1 cm), whereas simple VATS may be performed with two incisions of 0.5 cm. In their bilateral procedure, the patient must be rotated by 180° while under general anesthesia, whereas in simple VATS, the patient is in a semierect position, which does not need adjustment. In the present series, the procedure took substantially longer than regular VATS. The question is to what extent these drawbacks balance the three-dimensional view obtained with the robot. However, the data seem valuable, but some additional information is important from the pathophysiologic aspect of their results. Stating that 96% of patients had a complete resolution of their initial hyperhidrotic symptoms, do the authors mean that the hands were absolutely dry or that the amount of perspiration was reduced to normal levels? They observed compensatory hyperhidrosis in only 7.2% of patients, which is much lower than other studies, so how was it defined? Did the remaining 93% of patients have any degree of compensatory hyperhidrosis at all? Could the authors supply this additional information?

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