This short video reports 2 operative procedures performed in 2002 using a transdiaphragmatic extrapericardial approach of the IVC (see [video](#)). The first case was a 68-year-old man with a 10-cm hepatocellular carcinoma, which developed on postviral C cirrhosis. At the time of diagnosis, this tumor invaded the right hepatic vein, with tumor thrombus development in the IVC. A total vascular liver exclusion was required and a classical approach seemed hazardous due to the risk of thrombus fragmentation. A right hepatectomy with thrombus extraction was performed under 8 minutes of total vascular liver exclusion. The second case concerned a 47-year-old man with a peripheral cholangiocarcinoma, 15 cm in diameter, which developed in the left part of the liver associated with an important IVC compression and possible venous wall invasion (see [cavography](#)). To harvest this tumor, a total liver vascular exclusion was required, and the usual IVC approach was difficult to carry out due to local tumor development (see [video](#)). A left hepatic trisegmentectomy was performed under 33 minutes of total vascular exclusion. To check the absence of transmural venous tumoral invasion, a long cavotomy was achieved instead of troncular IVC resection.

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Disclosure Information: Nothing to disclose.

Concerns about Evaluating the Effect of Noise and Music in the Operating Room

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We read with great interest the arguments presented by Shawagfeh and colleagues in their letter “Noise or Silence in the Operating Room?” in the January issue of this Journal.¹ The authors presented a rational approach to this issue, which was addressed recently in this Journal² in response to the article by Way and colleagues entitled “Effect of Noise on Auditory Processing in the Operating Room.”³ Way and colleagues argued that music combined with operating room (OR) noise can produce a communication breakdown because it leads to a decrease in auditory processing of the surgeon when performing a demanding task (eg, the difficult part of an operation). Although we

agree with the authors that this might be the case, we would like to express some methodologic concerns. We consider the mean decibel level of the music and the OR noise rather arbitrary because the sampling procedure and the number of ORs from which the results were derived were not specified. Although a variety of earlier studies have proposed classical music (or similar low-tone music) as most appropriate in the OR,⁴ auditory processing was assessed with classic rock music. Finally, the Lombard effect (ie, a subconscious increase in vocal effort and volume in noisy situations) was not accounted for in their study.

Lee and colleagues⁵ published another study recently that suggested music as a potential distractor in the OR during urologic procedures. This particular study was an internet-based survey via email that assessed environmental factors (music among them) that could potentially affect the performance of personnel during an operation. Specifically, 15% of the responders considered at least one surgical complication to be the result of an external distraction (eg, music, pager, discussing consults, loud talking in OR, etc). However, the responders were never questioned solely on the impact of music in the OR and the complications were attributed to “external distractions” in general, without specifying the influence of music. In addition, music had been preconsidered an “external distraction” by the authors of the article and not the responders.

In our opinion, the impact of music in the OR should be divided into the following categories: effect on the patient, effect on the surgeon’s operative efficacy, and effect on the rest of the staff and their communication. Music has been shown to decrease patient demand for analgesic and anesthetic drugs.⁶ With regard to the surgeon’s operative efficacy, music seems to improve speed and accuracy of task performance,⁷ reduces average muscle activation, and eventually results in less muscle fatigue.⁸ However, music can potentially lead to miscommunication between OR personnel or even distract anesthesiologists from the various alarms of the monitoring devices. Music type and volume are critical to this debate. Despite personal preferences, it is common sense that loud and raucous music (eg, hard rock) can be detrimental to communication, and low-volume, low-tone music (eg, classical music) can evoke mental vigilance⁴ without being a barrier to communication. In addition, music volume is easily adjustable and can even be turned off if required.

In a nutshell, the question of music or no music in the OR is a matter of preference because there is no solid evidence-based answer. However, given the various beneficial effects of music, the investigation should be directed toward the type and volume of music that can be played without distracting OR personnel from performing their tasks. Finally, silence in the OR is never feasible; there

are always distractions (ie, pages, telephones, and loud talking) that constitute “OR noise.” In our opinion, these distractions are much more prevalent, have a greater impact, and are out of the surgeon’s control, and efforts should be made to eliminate them.

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Disclosure Information: Nothing to disclose.

Preventing Surgical Site Events: Any Role for Negative Pressure Wound Therapy?

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We read the extremely interesting article by Cima and colleagues,¹ which reported on a study conducted on behalf of the Colorectal Surgical Site Infection Reduction Team. The authors found that the incidence of surgical site infections was dramatically reduced by adopting The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). This is a very useful finding, given that surgical site infections may cause more than \$1.5 billion in excess cost in the United States.²

We recently published our experience with negative pressure wound therapy (NPWT) on closed incisional wounds by means of a portable device (PICO, Smith & Nephew) as a preventive measure in patients suffering from Crohn’s disease.³ The device generates a minimum vacuum negative pressure of –80 mmHg. We found that PICO significantly reduced the likelihood of surgical site events (SSEs) compared with conventional sterile dressings.³

Inflammatory bowel disease is an independent risk factor for SSEs.³ Moreover, these patients may need surgery at any age and often while receiving concomitant medications (ie, corticosteroids, immunomodulators, biologics), which can negatively affect wound healing.^{3–5} So, these patients should be considered “at risk.” Specifically, we observed that 1 of every 2 patients undergoing surgery for Crohn’s disease with primary wound closure while receiving corticosteroids would benefit from preventive placement of NPWT, the latter being significantly associated with SSEs in a logistic regression (odds ratio [OR] 0.21, 95% CI 0.15 to 0.5, $p = 0.001$).^{3,6} Balancing the limited costs of the PICO devices—not exceeding 200 euros in Italy—with the cost-consuming effects of a potential SSE,^{1,2} we recommend considering preventive NPWT placement on surgical wounds in patients at risk of developing SSEs. The ideal candidates for preventive NPWT are yet to be determined, but this approach should be considered when planning a perioperative pathway to reduce SSEs.

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Disclosure Information: Nothing to disclose.

Individualized Decision Making in Treatment

In Reply to Pellino and colleagues

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We thank Drs Pellino and Selvaggi for their critique and review of our article. Although we might agree not to