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European Journal of Cardio-Thoracic Surgery 42 (2012) 385
doi:10.1093/ejcts/ezs038

LETTER TO THE EDITOR RESPONSE

Reply to Nezic *et al.*

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Received 2 January 2012; accepted 5 January 2012

Keywords: Ascending aorta • Aortic valve • Valve composite graft • Bentall operation

We appreciate the comments by Nezic *et al.* [1] regarding our article [2]. Nezic *et al.* pointed out the pinholes of the everting mattress sutures on the flange as the potential sites of bleeding. However, a recent Gelatin-sealed woven Dacron graft was considered because the problem was rare. In addition, we injected fibrin glue around the proximal suture line after sewing the Valsalva sinus skirt to the residual aortic wall to prevent bleeding of the pinholes. Actually, no patient required re-exploration for bleeding. Therefore, we think that the flange side pinholes of everting mattress sutures are not the potential sites of bleeding.

As stated in their letter, sewing the residual aortic wall to the prosthetic sewing cuff or the prosthetic tube is a simple technique [3]. However, their technique is difficult to wrap tightly all of the proximal anastomosis line in case with the thin and fragile residual aortic wall or the inadequate length to contact the cuff after resection of coronary ostia. To prevent this problem, Chen *et al.* [4] made the corresponding portions of the flange long enough in order to sew between the residual aortic wall and the

flange. We used the Valsalva sinus skirt as the flange, which is soft and stretchable. This characteristic is useful to sew tightly the skirt to the residual aortic wall even in the cases.

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European Journal of Cardio-Thoracic Surgery 42 (2012) 385-386
doi:10.1093/ejcts/ezs091 Advance Access publication 22 March 2011

LETTER TO THE EDITOR

Systematic mediastinal nodal dissection and video-assisted thoracic surgery

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Received 14 December 2011; accepted 25 January 2012

Keywords: Video-assisted thoracic surgery • Non-small-cell lung cancer • Lymph-node dissection • Positron emission tomography

***Nullus est liber tam malus, ut non aliqua parte prosit* (There is no book so bad that it is not profitable in some part, Pliny)**

A recent study by Amer *et al.* [1] investigated the role of systematic mediastinal nodal dissection performed during video-assisted major pulmonary resection as a staging approach for non-small-cell lung cancer versus preoperative staging by computed tomography (CT) and positron emission tomography (PET). Precise staging is essential to provide accurate knowledge of disease progression in patients with non-small-cell lung cancer; in effect, the valuable editorial comment on the mentioned trial remarked that the authors 'ignored the data that support the use of mediastinoscopy prior to VATS lobectomy, even in clinical stage I disease' [2].

In reality, the American College of Chest Physicians clinical practice guidelines are open to the possibility that invasive staging is probably not needed in patients with peripheral tumours with no nodal involvement on CT and PET scans [3]. The coeval European Society of Thoracic Surgeons guidelines indicated that invasive staging can be omitted for patients with stage I lung cancer and negative mediastinal PET imaging on the condition that the tumour is peripheral [4]. From a formal point of view, the colleagues from Southampton could not be blamed for their preoperative protocol. Moreover, standard cervical mediastinoscopy usually only biopsies the paratracheal and subcarinal stations [4]; but, in order to reach every mediastinal station, transcervical extended mediastinal lymphadenectomy (TEMLA) [5] should be carried out. In addition, when positive lymph nodes are found, TEMLA should be redone for restaging after chemotherapy even if such a procedure seems excessive in a patient with a peripheral pulmonary nodule of a few millimetres plus negative mediastinal imaging. As an alternative, the endoscopic ultrasonography transbronchial needle aspiration (EBUS-TBNA) provides accurate mediastinal staging; such a technique is accepted by the American College of Chest Physicians and European Society of Thoracic Surgeons guidelines for clinical N2-3 lung cancer, but EBUS-TBNA has been proposed in the

staging of CT- and PET-negative mediastinum [6] our 6-year-long experience in EBUS-TBNA suggests that the biopsy of a few millimetre lymph-node is a hard duty especially in paratracheal stations. In conclusion, we consider that the Amer *et al.* preoperative behaviour is shareable and in good equilibrium between idealism and pragmatism [1].

Amer *et al.* underline the effectiveness of video-assisted thoracic surgery in the systematic mediastinal nodal dissection [1]. A number of studies had validated the video-assisted mediastinal dissection, but more explanatory is the simple photograph included in the article: during video-assisted thoracic surgery, the vision on mediastinal structures is so close and clear that surgeons can work in the best conditions. We conclude '*nullus est liber tam malus, ut non aliqua parte prosit*' (There is no book so bad that it is not profitable in some part, Pliny); the article from Southampton highlights an up-to-date clinical practice based on good common sense and, moreover, restates the feasibility of a complete mediastinal dissection during video-assisted thoracic surgery.

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European Journal of Cardio-Thoracic Surgery 42 (2012) 386-387
doi:10.1093/ejcts/ezs092 Advance Access publication 26 February 2012

LETTER TO THE EDITOR RESPONSE

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Received 20 January 2012; accepted 25 January 2012

Keywords: Video-assisted thoracic surgery • Non-small cell lung cancer • Systematic nodal dissection • Positron emission tomography