the best treatment leading to satisfactory long-term oncologic results has not been found yet.

The most important thing we learned about treatment of malignant pleural mesothelioma is that surgery plays an important role in cyto reduction, but it cannot be considered alone even in early stage diseases and it must always be associated with other therapies both in a neoadjuvant and adjuvant set [2]. In addition to this, a wide range of therapies may be added during surgery to increase the local control of the disease (intraoperative adjuvant chemotherapy, intrapleural iodine povidone solution, or photodynamic therapies).

Surgical approach is often evaluated by the surgeon case by case, and its choice is influenced by the stage of the tumor and its histology, and therefore survival and even postoperative courses may hardly be compared because patient cohorts are highly different: moreover, as reported by Wolf and colleagues [3], pleurectomy decortication and extrapleural pneumonectomy have different indications and they should not be considered as alternative treatments. Lastly, the definition of pleurectomy and decortication could be considered like a Pandora’s box because it contains a great range of lung-sparing surgical approaches, which could change depending on the surgeon’s technique [4].

Although this meta-analysis looks at a very interesting and challenging topic, is it really possible and meaningful to compare long-term survival of such a varied population of patients treated with a multimodal set of therapies?

Pietro Bertoglio, MD
Stylianos Korasidis, MD
Division of Thoracic Surgery
Department of Surgical, Medical, Molecular Pathology, and Critical Care
University of Pisa
Via Paradisa 2
56124 Pisa, Italy
e-mail: pieberto@hotmail.com

References

Reply
To the Editor:

There is no evidence-based proof that the adjuvant treatments mentioned by Drs Bertoglio and Korasidis [1], in their comments on our article [2], add any survival benefit to mesothelioma patients. However, historically surgery has been the mainstay of treatment. We agree that pleurectomy with decortication is a Pandora’s box of what many consider suboptimal oncologic procedures. Yet, survival with extrapleural pneumonectomy was still worse [3].

Emanuela Taioli, MD, PhD
Andrea S. Wolf, MD
Raja M. Flores, MD
Department of Thoracic Surgery
Mount Sinai Health System
Icahn School of Medicine
One Gustave L. Levy Place, Box 1023
New York, NY 10029
e-mail: raja.flores@mountsinai.org

References

Personalized Aortic Root Support With Mesh Provides Optimal Valve Conservation
To the Editor:

Gamba and colleagues [1] report a tissue-sparing procedure for aortic root ectasia which conserves the valve and the coronary ostia. We agree with them that current forms of aortic root replacement are technically demanding and time-consuming and that simplified ways of achieving the same objectives should be considered.

For sleeve procedures, stiff low-porosity vascular graft materials are used, and there is still a need to incise the aorta to support the valve. Another approach is computer modelling a soft pliant macroporous mesh that becomes incorporated in the adventitia to form a neoaortic wall. Personalized external aortic root support has been used in 50 patients since its introduction in 2004. The morphology of the root, and the support of the aortic valve, remain unchanged to beyond 10 years [2]. In the only patient to die with a support in place (of arrhythmia), there was evidence of healing of the aortic media [3].

It should be noted that the “intention to treat” of valve-sparing root replacement cannot always be achieved, and there is a subsequent re-operation rate of 13% per decade of life, predominately for aortic valve failure [4]. Operations on the aortic root entail intraoperative hazard, and a careful consideration of risk and benefit is implicit and should be made explicit to patients. There is room for improvement in what we have to offer them, particularly for those with congenitally determined aortic root aneurysm who have root surgery in their thirties and may have four or five decades of life, preferably free of further surgery or anticoagulation.

Conal Austin, FRCS
Cardiac Surgery
St. Thomas’ Hospital
London, United Kingdom

Tal Golesworth, C Eng
Existent, Ltd
Tewkesbury, United Kingdom
We would like to thank Dr Austin and colleagues [1] for their comments. The sleeve procedure was conceived to simplify the surgical approach for those patients with an aortic root disease already clinically relevant. Wrapping a diseased aortic wall, instead of replacing it, is less radical and thus may appear a less comprehensive approach, with possible drawbacks, than a classic valve-sparing approach (ie, the David and Yacoub operation). We are well aware of the personalized aortic support procedure that has showed, so far, encouraging results, as reported in the personalized aortic root support (PEARS) trial results [2]. The main differences with the sleeve procedure are a personalized computer modeling graft, made of soft macroporous mesh, and an earlier time for intervention. What the two procedures have in common is the wrapping of the aorta. According to both our data and the PEARS study, the external support may really prevent further enlargement of the aorta, avoiding the disastrous events related to the excessive dilatation. Besides, leaving the entire aortic root unit reduces stress both at the leaflet’s belly and the commissures than the David operation (unpublished data). After our recent appraisal of the sleeve procedure [3] and the results of the PEARS study, we began to address moderate aortic root dilatation (from 40 mm) with the sleeve technique when the surgical indication is a severe dilatation of the ascending aorta. Thus, the sleeve technique appears to be more versatile than other valve-sparing procedures. Because most patients in our study are relatively young, with still a long life expectancy, only time will answer the question whether wrapping the aortic root provides a stable and durable result. In the meantime, we are approaching the 10-year follow-up of our first patients operated on.

References

What Can We Do to Reduce Hospital Readmission After Lung Lobectomy?

To the Editor:

We read with interest the paper by Assi and colleagues [1] focusing on 30-day post-surgery complications and hospital readmission. We found it very interesting that hospital readmission was independent of surgical approach, in particular comparing thoracotomy with the video-assisted thoracic surgery (VATS) group, and of inpatient complications. On the contrary, readmission was influenced by unplanned transfer to the