

In conclusion, hybrid Nuss Procedure is a good alternative intervention for PE patients with severe retrosternal adhesions after sternotomy.

Shuai Li, MD
Shao-tao Tang, MD
Li Yang, MD

Department of Pediatric Surgery
Union Hospital
Tongji Medical College
Huazhong University of Science and Technology
1277 Jie Fang Ave
Wuhan 430022, China
email: tshaotao83@126.com

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Video-Assisted Thoracoscopic Lobectomy for Lung Cancer

To the Editor:

We read the article written by Abdelsattar and colleagues with great interest and meticulousness [1]. It has a multicenter study with a large patient population.

We perform the video-assisted thoracic surgery (VATS) lobectomy for approximately 50 patients with lung cancer per year in our region. We see this procedure as a gold standard for stage 1 lung cancer especially.

We do not suggest the treatment of lung cancer at provincial hospitals. Multidisciplinary and multimodal treatments with many departments are needed for these patients, and the specific centers are established. In our country, the VATS resections are performed for lobectomy generally; however, for some cases if there is no diagnosis with fine-needle aspiration biopsy performed using invasive radiology, we use VATS resections and intraoperative frozen section for diagnosis and treatment.

Our residents are training for VATS procedures, and they obtain experience with VATS resections step by step [2, 3]. The VATS resection is a very important surgical technique which has less mortality, less hospitalization time and is faster.

Murat Oncel, MD
Guven Sadi Sunam, MD
Huseyin Yildiran, MD

Selcuk University Medical Faculty
Department of Thoracic Surgery
Alaeddin Keykubat Kampüsü, 42000
Konya, Turkey
email: moncel01@hotmail.com

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Improved Closure Technique for Uniportal Video-Assisted Thoracic Surgery: Double-Embedding Stitching Method

To the Editor:

We read the articles by Son and colleagues [1] and Yang and colleagues [2] with great interest. Both of them showed concern about peritubular leakage and cosmesis of the incision after uniportal video-assisted thoracic surgery (VATS). Son and colleagues [1] moved the incision site down to the rib surface and used nylon for tube fixation that is anchored through the subcutaneous suture, whereas Yang and colleagues [2] placed the drainage tube within the intercostal space above the incision. We found that Son and colleagues' technique may cause additional operational inconvenience in some patients, whereas Yang and colleagues' method may cause damage to two intercostal nerves.

We were inspired by Son and colleagues' chest tube fixation procedure and Yang and colleagues' subcutaneous embedding technique. Before placing the chest tube, we embedded a 2-0 absorbable suture in the muscle layer around the chest tube site, with one end of the suture extending out of the incision (Fig 1A) and the other end knotted with another muscle layer suture. In the subcutaneous layer, a 3-0 absorbable suture was embedded around the chest tube with one end of the suture similarly extending out of the incision. The two lines thread extending from the incision were tied together (Fig 1B) and tightened slightly to reduce leakage around the tube. After the removal of the chest tube, the muscle and skin layers were sealed by tightening the two knotted lines (Fig 1D), which could be secured on the skin with tape and removed from the surface of the skin after 3 to 5 days.

In conclusion, we believe that the double-embedding stitching method could solve the problems of peritubular leakage and cosmesis of the incision after uniportal VATS.

Lijian Huang, MD
Lufeng Zhao, MD
Wenshan Li, MD
Ying Chai, MD

Department of Thoracic Surgery
2nd Affiliated Hospital
School of Medicine
Zhejiang University
88 Jiefang Rd
Hangzhou, China
email: chai_y@126.com

