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Transxiphoid Hand-Assisted Thoracoscopic Surgery: An Approach Included in the Armamentarium

Tommaso C. Mineo, Vincenzo Ambrogi and Eugenio Pompeo

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Reply

To the Editor:

In the report by Roehr and colleagues [1], initiation of parenteral octreotide (OCT) led to the resolution of loculated chylothorax and resumption of full-fat human milk (FFHM). Similar to our patient [2], their patient had chylothorax develop despite being maintained on total parenteral nutrition then low-fat formula. It was not until OCT was used that FFHM could be started. It should be noted though, that after OCT initiation, Roehr and colleagues [1] used FFHM much later than when we used it in our patient. In other words, in our patient, low-fat human milk was used as an adjunct to OCT treatment to replace other low-fat formulas. However, in the report by Roehr and colleagues [1], FFHM was introduced only after OCT treatment had resulted in near cessation of the chylothorax.

The two reports should stimulate further research into the role of human milk in patients with chylothorax, as it can be an important adjunct to whatever treatment modality is chosen. It has been shown that human milk contains a high concentration of somatostatin [3]. Once absorbed, ingested somatostatin may exert an inhibitory effect on the intestinal and pancreatic secretions [3]. Whether this has any clinical benefit in the reduction of chylothorax is currently unknown and is subject to further research.

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To the Editor:

With great interest we read the article by Detterbeck and Egan [1]. They advocated the usefulness of having one hand inside the

thorax during a thoracoscopic procedure. It is nice to read reports of this approach from other authors. We believe this approach was first described by us as a “How to do it” article in *The Annals of Thoracic Surgery* in 1999 [2]. At that time we chose the term “transxiphoid” because resection of the xiphoid allowed easy insertion of the hand into the thorax. A few years later this approach was appropriately termed *hand-assisted thoracoscopic surgery* (HATS) [3].

Our series now includes 61 patients with lung metastases approached by transxiphoid access. Complications were minimal. As predicted, the transxiphoid approach proved safe and effective with advantages (ie, less postoperative pain, shorter in-hospital stays, easier patient and physician acceptance). Nonetheless, we also found a lower risk of recurrence with longer disease-free intervals based on the more accurate exploration.

Since the first presentation, we were quite confident that this approach would be adopted worldwide. Now others [2] congratulate Detterbeck and Egan [1] for renewing interest in transxiphoid HATS, which we had already included in our standard armamentarium.

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Reply

To the Editor:

I am indebted to Mineo and colleagues for many innovative approaches in thoracic surgery, including the initial description of the transxiphoid handport. It was their report [1] that stimulated me to use this procedure. They appropriately deserve credit, as do Wright and colleagues [2] for variations on the approach. We thank Mineo and colleagues for their comments [3].

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