

Minimally invasive or sublobar surgery for congenital cystic adenomatoid malformation?

Doğumsal kistik adenomatoid malformasyonda minimal invaziv mi, yoksa sublober cerrahi mi?

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Dear editor,

We read the article by Erginel et al.^[1] in your journal with interest. I would like to address some questions and points to the authors on their innovative surgical approach.

First of all, I would like to ask the criteria for deciding on an open or a minimally invasive approach. Pros of video-assisted thoracic surgery (VATS) have well been shown and accepted, but the rationale of sublobar resection has not been clearly explained in the text. The lesion sizes are not clear in Table 1, but if they are in centimeters and not millimeters, performing a sublobar resection should have been dramatically challenging for multiple lesions of type 2 congenital cystic adenomatoid malformation over 10 cm (patients #13 and #20). Conversion rates to open surgery could have also been given, if any, with its reason.

My next question will be on the diagnosis stage of these patients and if the authors have detected any lesion by fetal ultrasound, since they have operated on neonatal patients as well. Four youngest patients indicated in "Patients and Methods" section as 39 days old are reported as 0.083 instead of 0.107 (39/365) years old, probably a simple typo, in Table 1.

The mean chest tube duration is relatively high in the thoracotomy group (5.3±0.5 days) according to the segmentectomy group (3.6±1.9 days). But in order to compare scientifically, exclusion of the VATS cases -a totally different surgical approach- would be more appropriate.

In current text books, lobectomy is recommended as the treatment of choice for all congenital cystic adenomatoid malformation patients,^[2] as the authors have also mentioned in their paper. I do also believe that minimally invasive approach and/or sublobar resection should be considered for these lesions in order to preserve as much healthy lung parenchyma as possible, since their embryological origin is of segmental nature; but within certain size threshold.

I would like to congratulate and thank the authors for sharing their experience.

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Author Reply

Thank you for your careful investigation of our paper and your contributions.

Lobectomy is generally preferred to wedge resection in congenital cystic adenomatoid malformation (CCAM), particularly in newborns, since there are technical difficulties with identifying planes of dissection and an increased morbidity associated with partial resection during open surgery. Thoracoscopy provides a better view for the dissection of the planes and evaluation of associated anomalies. The available localization of the lesion, exact excision line between lung, CCAM and adjacent structures, and sufficient experience of the surgical team are considerations when deciding upon wedge resection.



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In Table 1, the sizes are in centimeters. These sizes are those indicated in the pathology specimens according to detailed pathology reports. Our conversion rate was 2/7. The patient who was 39 days old was estimated as one month old (0.083, 1/12).

Regarding the highlights of this article and recent literature, although lobectomy is recommended

for all CCAM patients, we first prefer a lung protective approach with thoracoscopy for suitable patients.

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