

however, minimal N2 disease is found, in which a reasonable prognosis after surgical resection can be expected in comparison with patients with preoperative confirmed N2 disease [8]. An additional advantage of the PET scan in comparison with mediastinoscopy is that the PET scan can indicate suspected lymph nodes in stations not amenable to mediastinoscopy (eg, paroesophageal or supraclavicular).

Staging of the mediastinum using positron emission tomography is definitely better than staging using computed tomography alone, and therefore the PET scan has a definite role in noninvasive mediastinal staging independent of the availability and expertise in mediastinoscopy. In our view, the PET scan is able to reduce the need for mediastinoscopy and reduce the number of unnecessary thoracotomies. A clinician must always seek an accurate preoperative staging with a minimal need for invasive procedures. The use of PET scanning needs further validation in outcome studies. In a randomized design, these studies should examine whether positron emission tomography actually improves NSCLC management (eg, by decreasing the number of unnecessary invasive procedures or by improving the survival). In the future, fusion of the CT scan with the PET scan into one test may be helpful to further improve the diagnostic accuracy of these noninvasive imaging modalities.

We think that our considerations are not a matter of relearning lessons from the past, but are useful contributions to improvement of clinical staging of NSCLC patients. In that regard, we are making progress.

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## Loculated Neonatal Chylothorax Treated With Octreotide: Complete Recovery While on Unrestricted Full Fat Breast Milk

To the Editor:

We have read the article by Hamdan and Gaeta [1] with great interest. Their report of successfully initiating breast milk in a child treated with octreotide (OCT) for postoperative chylothorax addresses an important question regarding the adjuvant treatment of such children. In such patients, medical treatment will almost exclusively include total parenteral nutrition (TPN); however, this bears the risk of infection and hepatotoxicity. Therefore, any means to avoid or shorten the duration of TPN would be welcomed. The article suggests a possible drug treatment of children with chylothorax. We would like to communicate our experience on the successful use of OCT in a child with primary chylothorax.

A male infant of 34 week gestation with severe fetal hydrops and bilateral pleural effusions was delivered by Caesarean section at our clinic. The initial management included mechanical ventilation, bilateral thoracostomy drains, and diuretic therapy. Enteral feeds were commenced on day 2 but had to be discontinued as chylous pleural effusions occurred. The patient was changed to total parenteral nutrition and chest drains remained in situ for 20 days. The TPN was gradually replaced by a low fat formula (Milupa Basic-F [Milupa, Friedrichsdorf, Germany]; fat content < 0.07 g/100 mL). On day 53 of life he had developed tachypnea along with an oxygen requirement. A chest ultrasound showed a loculated, mainly right-sided thoracic effusion, and biochemistry that confirmed chylothorax. We commenced subcutaneous injections of OCT (Sandostatin [Novartis-Pharma, Switzerland]) to circumvent the risks associated with repeated thoracocentesis. The starting dose (as described by Cheung and colleagues [2]) was 10 µg/kg/d; total daily doses were incremented by 5 µg/kg/d to as much as a maximum dose of 40 µg/kg/d. Treatment effect was monitored by regular chest ultrasound. Normal respiration was restored while enteral feeds could be maintained, more so that the child was successfully changed to full fat human milk. Daily blood glucose levels, stools, blood pressure, and weekly serum electrolytes, liver function tests, and weight gain remained normal throughout therapy. By day 69, no further effusions were found and OCT was discontinued on day 74. A spiral computed tomographic scan on day 76 was normal. At 6 months of age he was thriving well and showed normal longitudinal growth.

Treatment with OCT quickly reduced thoracic effusions in this patient, which prevented further thoracocentesis and permitted the initiation of human milk without evidence of serious side effects.

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

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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