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Graft versus Host Disease (GvHD) is a serious complication following allogeneic stemcell transplantation. Lung involvement with a decline in FEV1 is a pulmonary manifestation of GvHD which occurs in 5 to 8% of SCT recipients. Early studies showed that bronchiolitis obliterans (BO) is the histological correlate of pulmonary GvHD and associated with a high mortality. In our institution VATS biopsy is still considered the gold standard to diagnose bronchiolitis obliterans, after pulmonary infection has been excluded by BAL. In this study we analysed the histological pattern and outcome of 22 patients with biopsy proven bronchiolitis obliterans. There were no major surgical complications of VATS in this immunocompromised patient group. Twelve patients showed constrictive bronchiolitis obliterans (CBO) on biopsy whereas there was lymphocytic bronchiolitis in 10 cases (LBO). Median FEV1 was 43.6% in CBO and 62.6% in LBO. There was no difference in age, underlying hematologic disease or pretreatment between the two groups. Almost all patients suffered from chronic GvHD. Median time to the diagnosis of bronchiolitis obliterans after allogeneic SCT was 558 days in CBO as compared to 703 days in LBO. FEV1 markedly improved in the majority of cases with LBO whereas FEV1 only partly improved in patients with CBO. Six patients died in the CBO group as compared to only one death in the LBO group.

**Conclusion:** The histological pattern of lymphocytic bronchiolitis obliterans is associated with a much better prognosis as compared to constrictive bronchiolitis obliterans following allogeneic stemcell transplantation. We recommend to perform VATS in patients with suspected bronchiolitis obliterans.

#### P2419

##### VATS lung biopsy is the method of choice for patients with ambiguous pulmonary pathology to establish a morphologic diagnosis

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**Objectives:** In spite of intensive development of diagnostic tools in pulmonology such as HRCT, PET, bronchoscopic examination peripheral lung lesions (PLL) and interstitial lung diseases (ILD) are often require excision lung biopsy for the morphological diagnosis. We evaluate the efficiency and safety of the VATS lung biopsy in the final diagnosis for patients with pulmonary diseases.

**Methods:** 230 patients with PLL (group I) and 87 patients with ILD (group II) were enrolled. Mean age: 54±20 y. We used HRCT for lesion(s) visualization in all cases. All patients in both groups underwent VATS lung biopsy and morphological investigation of the specimens to establish a final diagnosis.

**Results:** In accordance to preoperative examination in group I there were: neoplasm's, tuberculomas and hamartomas. In the group II there were suspicions to sarcoidosis, idiopathic pulmonary fibrosis (IPF), alveolitis or lymphangioleiomyomatosis (LAM). Morphological diagnosis was obtained in all cases. We found benign neoplasm 39%, early forms of lung cancer in 42%, tuberculomas in 12%, metastatic disease 4.2%, carcinoid tumors in 2%, and nidal fibrosis in 5.6% of all specimens in group I. In the group II there were sarcoidosis (48%), IPF (26%), alveolitis (24%) and LAM (2%). Accuracy of preoperative examination was 91% and 86% in the first and second groups respectively.

**Conclusion:** VATS lung biopsy provides adequate specimen volume for morphologic diagnosis and associated with 100% diagnostic accuracy. Minimal postoperative morbidity and mortality rates are justified this procedure as a method of choice for patients with ILD and PLD.

#### P2420

##### Surgical treatment for lung metastases in patients with colorectal cancer

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**Introduction:** The paper presents a history of surgical treatment for lung metastases from colorectal cancer and subsequently an analysis of the treatment results, presenting some differences of lung metastasectomy.

**Materials and methods:** A review of the literature from the years 2000-2010 for the resection of metastatic tumors of colorectal cancer and our experience and results from the material of 60 patients operated in our unit in 2004-2007.

**Results:** Pulmonary metastasectomy of the secondary lesion of the colon gives the best results in cases of primary low pathological staging of a resectable primary colorectal cancer (T1 to T2 preferably limited to 3 number of lung metastases and/or a one metastasis to the liver disease in free time exceeding 36 months and the normal level of intestinal-embryonic marker.(CEA). Conversely-factors pleading for the surgical resection renouncement for metastases are: medium and high degree of advanced colorectal cancer (T3-4, N1-2), multiple metastases to the lung or liver disease-free time of less than 12 months and an increase in serum CEA (above 10 ng/ml).

**Conclusion:** 1. Results of surgical treatment of metastatic colorectal cancer to encourage a wider patient eligibility, taking into account prognostic factors. 2. Decisions about the way of surgical treatment for metastatic disease should be taken

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#### P2417

##### Diagnostic surgical lung biopsy in hematologic patients with pulmonary complications

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Pulmonary infectious and non-infectious complications are frequent in hematologic patients. If there is antibiotic resistant fever or persistent infiltrates bronchoscopy is performed. However in a considerable number of cases bronchoscopy is inconclusive and lung tissue needed to achieve a definitive diagnosis. We assessed the diagnostic yield and risk of VATS biopsy or open lung biopsy (OLB) in hematologic patients suffering from pulmonary complications. 81 patients with a mean age of 47 years underwent VATS (73%) or OLB (27%) from 2000 to 2010. 49 patients underwent allogeneic and 7 autologous SCT, 21 had high dose chemotherapy. Examinations revealed an infectious agent in 6 (Tbc, 2 Pcp, 2 bacterial, echinococcus), bronchiolitis obliterans in 23, organizing pneumonia in 8, diffuse alveolar damage in 8, NSIP in 2, and lymphoma in 3 cases.

There was no perioperative death. A prolonged ICU stay (>72hours) was needed in 11 cases. 5 of these patients were already on the ICU prior to surgery. Re-operation was needed in 6 cases. No wound infection was observed. Thorax drainage was prolonged (> 5d) in 12 patients (15%). One patient developed a pneumothorax 12 days after VATS during a flight. 30-day mortality was 7% (6/81): 4 diffuse alveolar damage, 1 fungal infection/renal failure and 1 OP/renal failure. 2 of the 6 deaths occurred in patients already ventilated prior to surgery.

**Summary and conclusion:** The diagnostic yield of lung biopsy in hematologic patients is very high directly affecting patient management. The risk of the surgical procedure itself is acceptable. Mortality is increased in patients ventilated prior to surgery and in those with diffuse alveolar damage on histology.

#### P2418

##### Lung biopsy predicts outcome in bronchiolitis obliterans following allogeneic stemcell transplantation

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based on the assessment of the patient (organ function), number of metastases, and the value of CEA. 3. Regardless of the primary cancer focus, the G feature of differentiation, the number and size of metastases surgical resection extend patients life.

**P2421****The role of VATS in the staging of non small cell lung cancer**

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**Introduction:** One of the points discussed in NSCLC always has been to use staging method with high accuracy, including bronchoscopy, CT scan, PET scan and mediastinoscopy.

Another completing method for staging is VATS. In our study we decided to evaluate diagnostic accuracy of VATS for staging of NSCLC.

**Material & methods:** The case series study was performed on 40 NSCLC patients from 2007 to 2010. After complete preoperation evaluations (history and physical exam, CXR, CT scan, bronchoscopy, TTNB and mediastinoscopy if needed in some cases) patients without criteria of inoperability have been reevaluated with VATS staging before the surgery. Thoracotomy was performed after VATS, when we didn't have any exclusion criteria for surgical resection. We evaluated diagnostic accuracy of VATS.

**Results:** 40 patients were studied (M/F = 21/19), the mean age was 57 year. The most common symptom was coughing (90%). The most common finding of CT scan of the patients was mass lesion in 100% patients. The endobronchial lesion was seen in 29 patients. We performed mediastinoscopy on 7 patients for staging because of N2 lymph node size more than 1 cm, which was negative finding for metastatic involvement. 6 patients haven't been candidates for surgical resection after performing VATS (3 patients for pleural seeding, 2 patients for N2 lymphatic involvement, and one for stellate lesion in other lobe). Thoracotomy was done on 34 patients. Operation was successful in 31 patients complete resection and failed in 3 patients due to hilar extension of tumor. The diagnosis accuracy of VATS was 92.5%.

**Conclusion:** According to high diagnostic accuracy and easy to performance of VATS we recommend it to be done before surgery.

**P2422****Therapeutic pulmonary metastasectomy for colorectal cancer should be chosen in any disease-free interval, size of tumor, and carcinoembryonic antigen level**

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**Aims:** We retrospectively review our experience of pulmonary resection of metastases from colorectal cancer, in order to document postoperative clinical outcome and survival.

**Methods:** From 2003 to 2010, in 16 patients, 19 pulmonary metastases from colorectal cancer were therapeutically resected in our hospital (9 were rectal and 7 were colon; 10 males and 6 females; mean age 66.3 years). The indication for these metastasectomies was based on Thomford's advocateship. They were analyzed retrospectively to calculate prognosis, and reviewed to verify their disease-free interval (DFI: interval between resection of primary tumor and diagnosis of lung metastases), size of largest resected metastases, pre-metastasectomy carcinoembryonic antigen (CEA) level with the reported prognostic factor. After lung metastasectomy, patients were followed up for 2- 95 months (median: 45.5 months).

**Results:** There was no operative mortality. Complications occurred in 3 out of 16 patients (19%) but were major only in 1 (6%). Overall, 3- and 5- year survival rates, from the date of pulmonary metastasectomy were 78.6% and 48.1%, respectively. The mean of DFI was 19.9 months (0- 99), the mean size of largest resected metastases was 22.6mm (9- 60), and the mean of pre-metastasectomy CEA level was 5.1 ng/ml (1.0- 32). These factors were not associated with longer survival.

**Conclusion:** Based on our experience, a good prognosis can be expected after therapeutic pulmonary metastasectomy for colorectal cancer regardless of factors such as DFI, size of metastasis, pre-metastasectomy CEA level.

**P2423****A rare solitary pulmonary plasmacytoma case**

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Solitary pulmonary plasmacytoma is extremely rare tumor therefore, we present clinical and surgical features of our case that is diagnosed postoperatively.

Fifty-year-old female patient was referred to our hospital for further examination since a lesion was identified on chest radiograph during the preoperative investigations for gall bladder surgery. In radiological investigations, a homogeneous lesion, about 4cm diameter, contoured quite smooth, showing the central location was detected. There was not any intrabronchial pathology in performed fiberoptic bronchoscopy. Due to the localization of the lesion without the need for another diagnostic process, thoracotomy was performed for diagnosis and treatment. In exploration, a mass lesion with smooth margins, seated on major fissure that invades middle and lower lobe was detected. Frozen section of the mass was

reported as a carcinoid tumor. Lower-middle bilobectomy and mediastinal lymph node dissection was performed since the tumor invades both lobes. It was reported that the tumor was Solitary Plasmacytoma and the lymph nodes were reactive lymphadenitis in immunohistochemical studies on the pathological evaluation of tumor. The patient was discharged without any problem. Postoperative bone marrow biopsy was performed. The result was negative.

Solitary plasmacytoma manifesting as a solitary pulmonary tumor is very rare. For this reason, a full review is necessary to distinguish a systemic disease. In addition, over time, the majority of cases of pulmonary plasmacytoma can change into multiple myeloma must be considered and patients should be followed up closely.

**P2424****Synovial sarcoma metastasis case performed aggressive pulmoner surgery**

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A 32 -year- old male patient who underwent amputation one year ago due to the synovial sarcoma that is on the distal phalanx of the toe of the right foot and after that received 6 cycles of chemotherapy was admitted to our clinic when he had hemoptysis and an opacity seen on right upper zone of his chest x ray at his last follow up. 8-10 cm-sized mass in the right upper lobe was diagnosed radiologically. Bleeding was seen from the mouth of right upper lobe in the patient's preoperative rigid bronchoscopy. In operation the upper lobe was filled with fluctuated, hemorrhagic, necrotic tumor tissue and the other lobes were normal. Right upper lobectomy was performed. It was reported that synovial sarcoma metastasis in pathologically. A 3 cm nodule was diagnosed in the left lower of the patient and videothoroscopic wedge resection was performed. Pathologically, that was also synovial sarcoma metastasis. The patient underwent 4 cycles of chemotherapy more. Four months later, he admitted with recurrence on the left side again, but the patient refused surgery. Two months later he was admitted as an emergency with severe shortness of breath. Left pneumonectomy and partial 8.th rib resection was performed due to the giant parenchymal mass that was fragile, bleeding, pushing mediastinum, invade chest wall and occupying the left hemithorax completely. Extensive chest wall resection was avoided since it increases the mortality and morbidity of the operation. The tumoral masses that destruct the lung completely were reported as synovial sarcoma pathologically. Shortness of breath improved in the postoperative period and he was discharged at eleventh day. The patient died 3 months after discharge day.

**P2425****Diagnostics of single lung formations using the robotized complex "da Vinci"**

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**Aim of the study:** An estimation of possibility of the robotized surgical system in diagnostics of single lung formations.

**Materials and methods:** There were made 60 the robot - assisted operations on thorax organs using the robotized complex "da Vinci", from them 23 patients were with single lung formations. The above-stated formations were localized in cortical and subcortical departments of a lung and had the size from 1,0 to 3,0 sm. All patients were performed the endovideosurgical regional lung resection by means of sewing devices Endo Gia - 45 and urgent histologic research biopsy material was made. Duration of operation was from 2,0 till 3,5 o'clock.

**Results of research:** The peripheral lung cancer was established at 8 patients, solitary metastasises - 5, hamartochondroma - 9, tuberculoma - 1. The patients with a lung cancer (8) have made lobectomy in conditions of thoracotomy access. The intra- and postoperative complications were absent. The average postoperative period after endovideosurgical operations was 3,5 days. The method advantages were small invasiveness, high possibilities of manipulators and use of the three-dimensional image. A combination with increasing allows to work confidently enough with vascular and tissue structures in small anatomic spaces. An absence of possibility of tissue condition evaluation using palpation complicated the work.

**Conclusion:** The first experience the robot - assisted operations has shown their high efficiency (100%), small invasiveness and relative safety in diagnostics of single lung formations.

**P2426****Castleman's disease presenting as a pleural mass in the thoracic cavity**

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A 61-year-old Turkish woman presented with a 10-month history of chest pain. Chest radiography showed nonhomogeneous density obliterating left costophrenic sinus. Chest computed tomography revealed a heterogeneous mass measuring

40×60-mm with calcification and necrosis at left posterolateral hemithorax. Bronchoscopy was normal. CT-guided cutting needle biopsy was nondiagnostic. Magnetic resonance imaging revealed 40×60-mm sized mass having central calcification and necrosis at left posterolateral hemithorax. On thoracotomy, an extraparenchymal mass destructing the ribs was determined. Mass excision and partial chest wall resection were performed. Grossly, the mass was pinkish yellow in colour and had a rubbery consistency with fibrous bands. Microscopic examination was characterized by germinal follicles surrounded by concentric layers of small lymphocytes and proliferative hyalinized vascular stroma in parafollicular area. All tumor cells stain positively with CD45, and negatively with pancytokeratin, while the follicular cells stain positively with CD20, and the parafollicular cells stain positively with CD3, immunohistochemically. The final diagnosis was angiofollicular lymph node hyperplasia (Castleman's disease) hyaline-vascular type in pleura.

**P2427****Salvage lung resection for local recurrence after stereotactic body radiotherapy for primary and metastatic lung cancers**

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**Introduction:** Stereotactic body radiotherapy (SBRT) has been proposed as an alternative to surgical resection for primary and metastatic lung cancers, for patients under inoperable condition based on poor lung function and/or senility. Sometimes, such patients refuse surgery and chose SBRT for the first treatment as a less invasive therapeutic option. However, surgical outcomes for local recurrence after SBRT were still unclear.

**Methods:** To further understand the indication for salvage lung resection, we retrospectively reviewed 9 patients (3 with stage I non-small cell lung cancer and 6 with metastatic lung tumors) who underwent salvage surgical resection for local recurrence after SBRT.

**Results:** Of the 9 patients, 7 underwent lobectomy, and the remaining 2 did bilobectomy and segmentectomy, respectively. 2 with metastatic lung tumors had pleural adhesion resulted from SBRT-related fibrosis. However, there was no case in which SBRT made surgical procedure impossible. Retrospectively considering the course after SBRT, once all 9 irradiated tumors resulted in disease progression, they grew in size rapidly.

**Conclusions:** We have treated all patients without major technical difficulties by SBRT-related change. SBRT did not close the door to perform salvage surgical resection, and surgical resection might be feasible for local recurrence after SBRT. However, close follow-ups are mandatory for patients treated with SBRT because tumor regrowth after SBRT is thought to occur at a rapid rate. And if patients are medically fit for surgery as the first line treatment, the use of SBRT should not be decided by only reason of its less invasiveness.

**P2428****Surgical treatment of postoperative chylothorax with thoracoscopy**

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We studied the results of the examination and treatment of 14 patients with postoperative chylothorax for the period from 1999 to 2010. There were 11 men (78,6%) and 3 women (21,4%), the mean age was 45.5±4.34 years. Pleural effusion in all patients was one-sided, i.e. on the side of the operation.

The cause of chylothorax of all the patients was surgery in the thoracic cavity -thoracotomy with resection of the lung and mediastinal lymph dissection (8 cases), lung resection without lymph dissection (2 cases), mediastinal tumor resection (3 cases), and pneumonectomy with intrapericardial treatment of vascular root of the lung (1 patient). Pleural effusion during chylothorax is rated as the milky in 6 (42,9%) cases, festering in 1 (7,1%), serous in 4 (28,6%) and hemorrhagic in 3 (21,4%) cases. The average concentration of triglycerides in the exudates was 7.13±2.12 mmol/liter. The thoracoscopy was performed to all the patients with drainage of the pleural cavity, a diet with a decrease in the amount of fat was prescribed. Total parenteral nutrition was originally required for 4 patients, and 3 patients were urged to follow it due to the ongoing chylorrhea after 3-4 days. Sandostatin was included in the conservative treatment measures of 5 patients. Conservative measures were effective in 9 patients. One patient underwent pleurodesis with intrapleural injection of Iodine polyvinylpyrrolidone complex solution. Other patients after unsuccessful conservative treatment for 7-10 days underwent thoracic lymphatic duct ligation. In the absence of the conservative measures effect for 7-10 days and in significant losses of lymph the surgical treatment was advised. Method of choice is ligation of the thoracic lymphatic duct.

**P2429****Five consecutive cases of left bronchial transcervical video mediastinoscopic closure**

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**Objective:** The author reports the longest series of left bronchial transcervical closure using video-assisted mediastinoscopy, describing his experience with this technique and the particularities of the cases. Left bronchial closure as the first procedure of a two-step pneumonectomy for TB compromised lung is a rarely used technique.

**Case report:** Five patients, mean age of 41.5 years, two females, three males, underwent videomediastinoscopic closure of the left main bronchi in the last 14 months, two for postpneumonectomy bronchopleural fistulas and three prior to pneumonectomy in TB destructed lung. The recovery was uneventful in every case, with the patients discharged the following day. The mean operative time was 55 min. No other incidents or procedure related complications were encountered. The three pneumonectomies followed at 3-4 weeks after the bronchial closure.

**Discussions:** The mediastinoscopic bronchial closure is a novel option in highly selected patients. The positive factor influencing our decision were the virgin mediastinum. The dissection of the trachea through its natural route enables tracheal mobilization. It warrants minimal surgical trauma, and, if necessary, the bronchial stump has enough time to heal before the difficult pneumonectomy.

**Conclusions:** Video-mediastinoscopy is an alternative to the open methods as it allows approaching the left main bronchi via the mediastinum. This technique is our choice because its specific morbidity is minimal compared with transpericardial sternotomy or a transthoracic approach. The mediastinoscopic approach is a novel option in highly selected patients in order to prepare and simplify a pneumonectomy.

**P2430****Value of the video assisted mediastinoscopy in the thoracic pathology – Our experience**

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**Introduction:** The oncological thoracic pathology is growing in the last decades because of the higher exposure to the pollution and because of the higher accuracy of the diagnostic. The mediastinoscopy offers the possibility of the diagnostic histopathology and of the accurate stadialisation in every thoracic pathology.

**Material and method:** We retrospectively reviewed 218 patients with cervical mediastinoscopy (151 males and 67 females, mean age: 52,3 years) treated between 2008 and 2010. The indications of the cervical mediastinoscopy is indicated in table 1.

Table 1. Indications of mediastinoscopy

Pathology	Number of patients	%
Suspected sarcoidosis	33	15.1
Suspected lymphoma	22	10
Mediastinal lymphadenopathies	22	10
Pulmonary carcinoma	111	50.9

We biopsied at least two nodal station.

**Results:** The results of this procedures are indicated in table 2.

Table 2. Types of histology

Histology	Number of patients	%
Sarcoidosis	32	14,67
Lymphoma	21	9,63
Tuberculosis	2	0,91
Small cancer	13	5,96
Non-small cancer	96	44,03

The method was not successful in four cases, which necessitated another procedures of diagnosis (thoracoscopy). For non small lung cancer the mediastinoscopy was a method of diagnosis in 79% of cases for patients contraindicated for pulmonary resection (metastasis, cardiac or respiratory dysfunction, mediastinal invasion). In 18,75% of non small cancer we applied a neoadjuvant treatment with secondary resection.

There was no intra- or postoperative mortality in this material. No major bleeding necessitating further surgical occurred. There weren't wound infection.

**Conclusions:** We still consider mediastinoscopy as a safe and efficient way of examining mediastinal pathology.

**P2431****Spontaneous pneumothorax and Marfanoid phenotype**

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It well-known that the spontaneous pneumothorax (SP) and apical bulls are diagnostic criteria of a Marfan syndrome. However the Marfan syndrome is a rare pathology, and the SP at tall and thin young men meets very often. For the purpose search of features of a Marfan syndrome has been surveyed 270 patients with a primary SP. Among patients men (n=248) prevailed, middle age of patients has made 24 years.

We have analysed major and minor criterions of the Marfan syndrome in the skeletal system, ocular system, cardiovascular system, skin and integument and dura. Skeletal major criterion met most often. Anterior chest deformity have been diagnosed for 14 patients, at 33 patients is noted reduced upper-segment to lower-segment ratio or arm span to height ratio more 1.05, at 62 patients were wrist and thumb signs. Scoliosis or spondylolisthesis have been taped at 45 patients. Medial displacement of the medial malleolus, causing pes planus were observed at 28 patients. Skeletal minor criteria and their combinations have been diagnosed for 112 patients. Dilatation of the ascending aorta and other are not diagnosed in one case. However such minor criteria as mitral valve prolapse has not been diagnosed for 125 patients. Skin and integument criterion have been diagnosed for 38 patients. Ocular and dura criterion met seldom. The combination of criteria has not allowed to diagnose Marfan syndrome at one patient, however allows to speak about presence Marfanoid phenotype at the patients with a SP. The finding of a strong association of SP with Marfanoid phenotype suggests that in many patients may be a manifestation of a systemic abnormality of connective tissue.

**P2432****Bronchial stump insufficiency after pneumonectomy in purulent-destructive diseases of lungs**

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As is well known, bronchial stump insufficiency (BSI), bronchopleural fistulas (BPF) and connected with them empyema pleura are the main reasons of the reduction to efficiency of the surgical treatment of lung cancer, purulent-destructive diseases of lungs (PDDL) and other surgical pathology of thorax.

**Material and methods:** Results of complex examination and treatment of 684 patients had comparative analysed, from which 575 (84.1%) patients underwent pneumonectomy (PE) on cause oncological pathology or PDDL, but 109 (15.9%) patients were treated on cause BPF after PE. The average age 56.4±4.1 years. The main group has formed 98 patients, admitted for 2006-2008 and undertaken designed tactics of the surgical treatment, founded on determination of the groups of the risk of the development BSI after PE.

**Results:** The frequency BSI after PE depending on presence different factor among 87 patients with PDDL was apart considered. PE is on the right made in 25 (28.7%) patients, on the left in 62 (71.3%) patients. BSI after PE is revealed in 4 (16.0%) and 7 (11.3%) accordingly. PE on cause PDDL noted increasing of the frequency BSI from 10.5% to 12.6% (11 from 87 patients), and risk of the development of this complication, depending on side of the operations forms - 16.0% after right-side and 11.3% after leftside PE.

**Conclusions:** In patients of oncological profile, which is planned PE, frequency of accompanying COPD forms 53.8% patient then in patients with PDDL this factor reaches 75.2%, in turn exacerbation COPD after performing PE noted in 48.8% and 63.6% patients accordingly, but risk of the development BSI on this background reaches 16.5% that requires including in the treatment nebulised therapy.

**P2433****Congenital pulmonary airway malformation in a 10 year old male adolescent**

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Congenital pulmonary airway malformation (CPAM), more commonly and previously termed congenital cystic adenomatoid malformation is an uncommon anomaly characterized by multicystic lesions due to proliferation of the respiratory bronchioles. This lung anomaly has an incidence of 1:25,000-35,000 and 90% of this number occurs in children below 2 years old. Late-onset CPAM is an infrequent illness and requires a high level of suspicion. It usually presents in the form of

repeated infections but very rarely remains to be asymptomatic until its diagnosis. This is a case of a previously healthy, apparently asymptomatic 10 year old male adolescent who had an incidental finding of a pulmonary bulla on chest radiograph taken while he was worked up because of a high grade fever which eventually he was diagnosed of dengue fever. He underwent elective right upper lobe lobectomy and was discharged improved on the 4th post-operative day. The final histopathologic result is consistent with a congenital pulmonary airway malformation, type 1.

**P2434****Latex tissue glue (LTG) application in lungs surgery and thoracic traumas for sealing lungs tissue: Suture, bronchial stump**

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Stable sealing of lungs tissue is the core principle and the key condition for positive results of postoperative recovery period after thoracic surgery. Hardest complication in thoracic surgery is the inconsistency of bronchial stump, the bronchial fistulas (15.5%). Due to this possibility of glue usage for lung surface processing with sealing effect is the most actual for thoracic surgery; as the possibility of adequate elasticity while lungs tissue elongation with min. collateral effects.

The advantages of LTG: inexpensiveness, highly adhesiveness and hydrophilia, ability to change elasticity, viscosity, adhesiveness, high rupture strength, microbiological stability, low toxicity. In our thoracic department actively applied till September 2010 latex glue, resulted drainage period average 2-3 days after operations (in purulent-destructive processes max 5 days).

Traditionally the average drainage period more than 5-7 days, and more complications. The larger scale of application is possible but not happen due to lack of financing from our hospital administration.

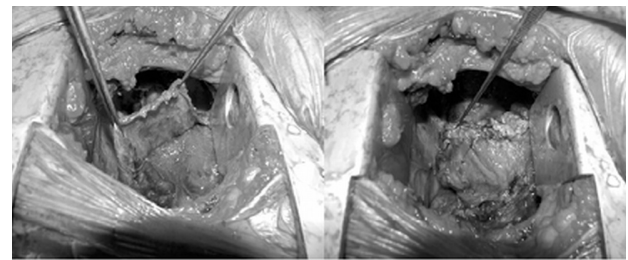
**P2435****Lung volume reduction surgery for a decompensated COPD – Case report**

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**Introduction:** Lung surgery reduction is a known method which can improve the quality of life for certain COPD. Parts of the lung that are particularly damaged by emphysema are removed, allowing the remaining, relatively good lung to expand and work better.

**Clinical features:** The work presents a patient with stage IV COPD admitted in our service after a severe decompensation. Comorbidities: severe obesity, chronic coronary ischemic disease and diabetes, left pneumothorax (secondary a giant bulla of emphysema) and infectious pneumonia. We maintained the antibiotherapy and we applied an anterior pleurotomy on the left medioclavicular line. The evolution was initially good with suppression of the tracheostomy's canule and of the pleurotomy's tube in five days.

**Surgery:** 48 hours after removing the chest tube, the pneumothorax recurred and we decided the surgery treatment. We performed the resection of the giant bulla and mechanical pleurodesis.



After opening of the bulla we used a fold of visceral pleura to covering the cavity in separated points.

**The outcomes:** The postoperator evolution was very good with spontan closure of the tracheostomy and with ablation of the tube in a week. The respiratory test indicated a improved with 15%.

**Discussion** Lung volume reduction surgery is indicated in selected cases, after surgery both lung functional tests and clinical performance of the patient being improved.

**Abstract P2434** – Table 1. Patients with application of latex glue

Diagnosis / Operations	Number of patients	Airtightness before 3 days	Airtightness for 3–5 days	Airtightness more 7 days	Complications (residual cavity)
Bullous, polycystic lungs / Atypical resections (sew instruments), pleurectomy	10	9	1	0	0
Necrotizing pneumonia, empyema / Decortication, atypical resections, pleurectomy	5	3	1	1	1 (tbc)
Abscess / Lobectomy, segmentectomy	5	1	3	1	1 (tbc)
Gangrene / Lobectomy, segmentectomy, pneumonectomy decortication	2	1	1	0	0
Trauma lungs / wound closure	1	1	0	0	0
Bronchiectatic / segmentectomy, lobectomy	1	1	0	0	0
Cancer / pneumonectomy	1	1	0	0	0

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**P2436****Foreign body; same clinic-different diagnosis**

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Foreign body aspiration is a serious condition with risk of mortality. It happens at all ages but mostly at childhood. Chest x-ray can demonstrate the foreign body if it is radioopaque. But laterally and oblique chest graphics must seen for the exact diagnosis with its size and localization. We report two cases admitted with same symptoms indicate to foreign body but different final diagnosis.

**Case 1:** A 1.5-year old child with Down syndrome was admitted to emergency clinic of our hospital with cough, wheezing and stridor. There was a history suitable for a foreign body aspiration and no any other significant history. Chest x-ray demonstrated an opacity similar to a foreign body. We performed a rigid bronchoscopy. There was no foreign body in his tracheobronchial system. Thereby esophagoscopy was performed under scopy. Again there was no foreign body although the image was suitable to a foreign body. In the postoperative period with a more detailed investigation it was understood that the radiological opacity was an endovascular stent set up with angiography to carry on PDA for another cardiac disease treatment.

**Case 2:** A 7-year old child was admitted to our hospital with persisting cough, wheezing and stridor. Clinical history and chest x-ray demonstrated a foreign body similar to the first case. Rigid bronchoscopy was performed and a metallic foreign body (pencil bow) is extracted from left main bronchus.

History takes a great role in diagnosis of foreign body aspiration. Radiological investigation must perform to all suspected cases. Although a chest x-ray demonstrate mostly atelectasis and hyperaeration at the affected side a normal graphy can not eliminate the foreign body. If the suspicion persists we must apply bronchoscopy.