Surgical Management of Thoracic Diseases

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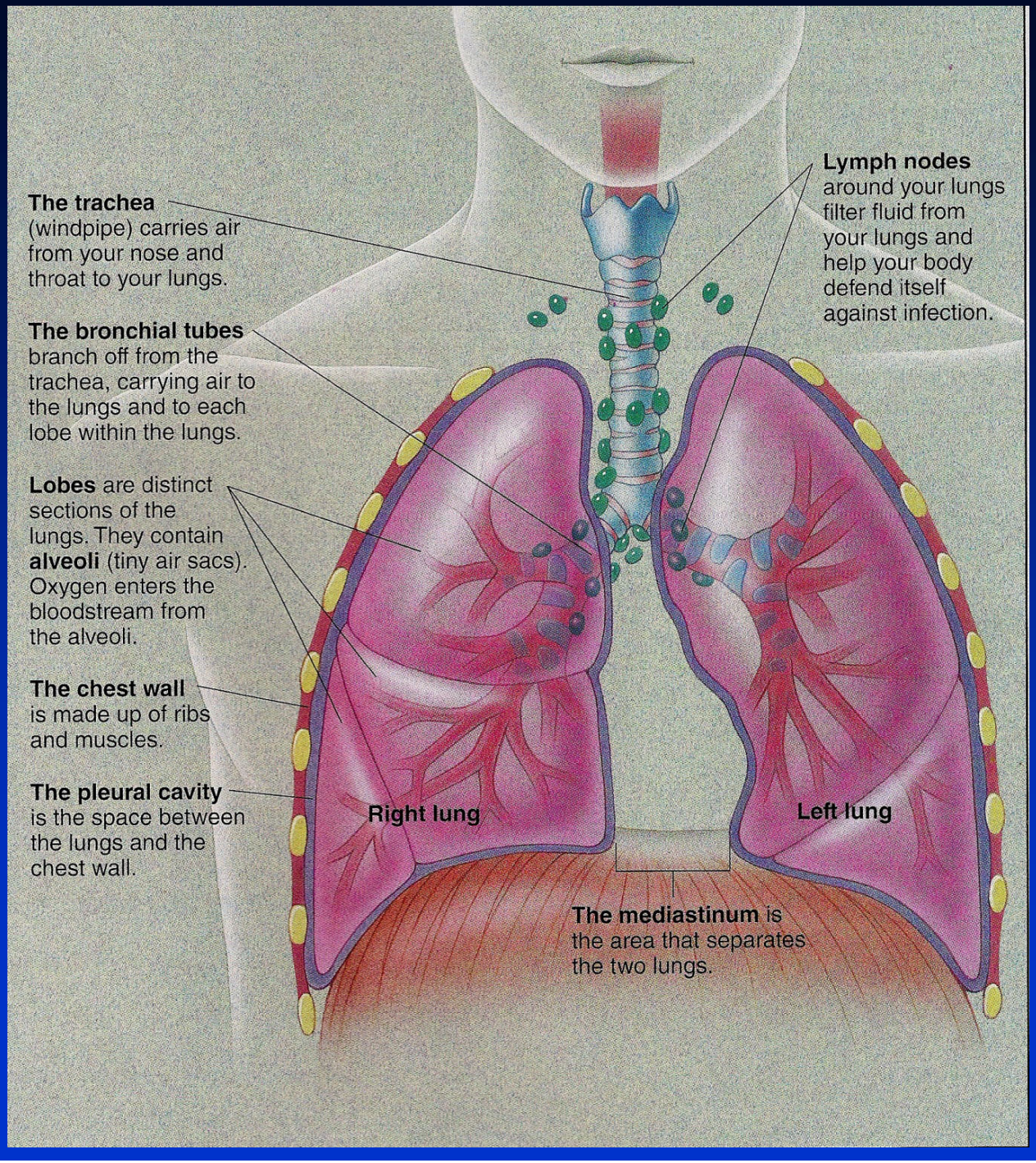
Goals

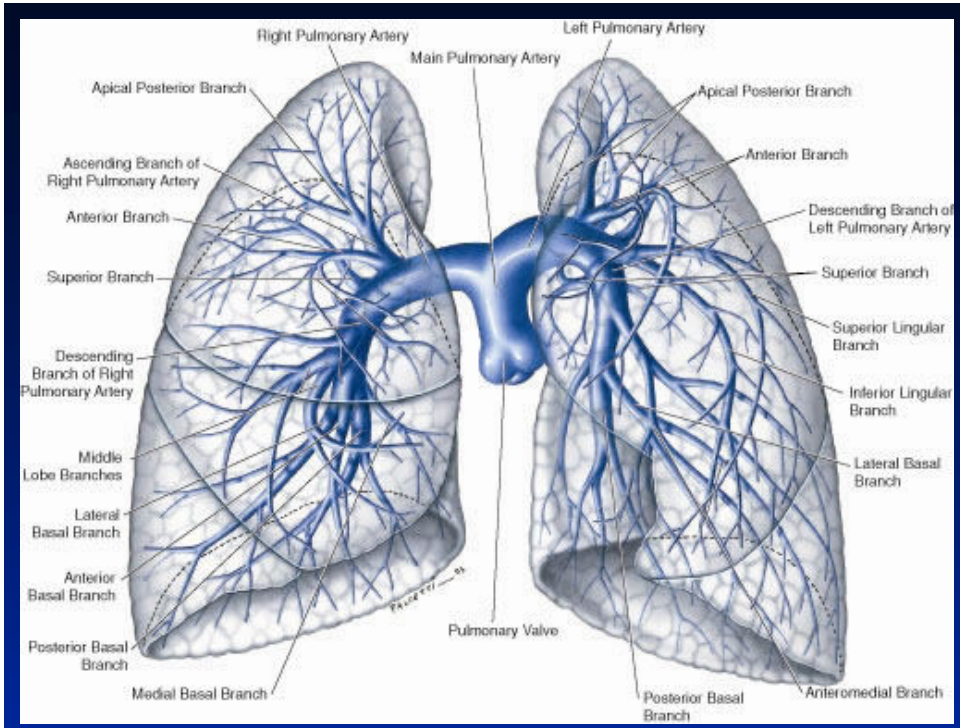
- Review relevant Anatomy of Thoracic Surgery
- Describe Major Thoracic Procedures, their indications and techniques with emphasis on a minimally invasive approach
- Brief review of Lung Cancer epidemiology
- Review Postoperative care for Thoracic surgery patients with emphasis on Pitfalls / Complications

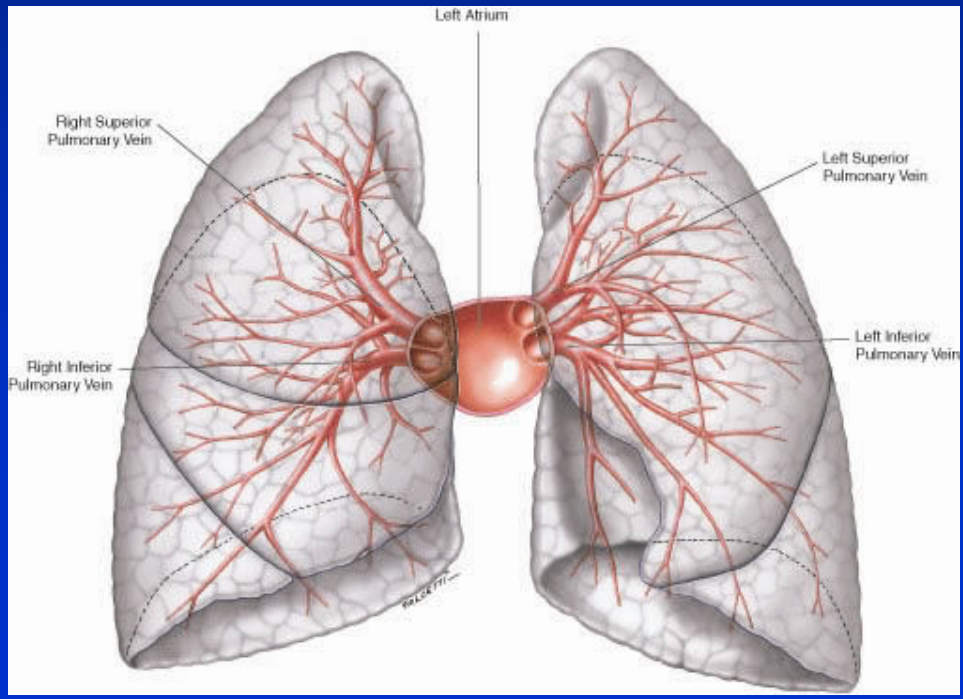
Disclaimer

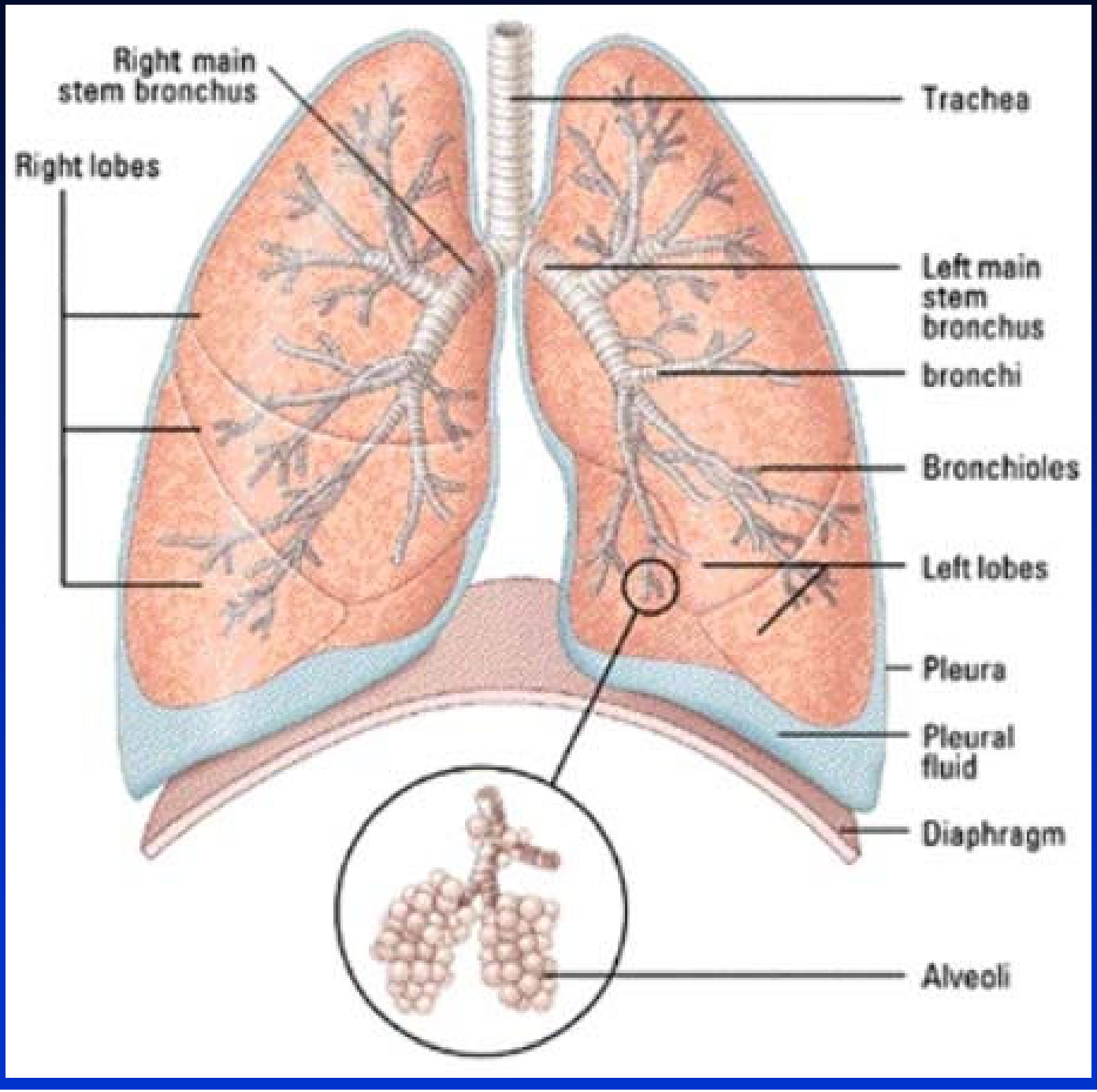
I have NO personal financial relationship with any manufacturer of products or services that will be discussed in this lecture.

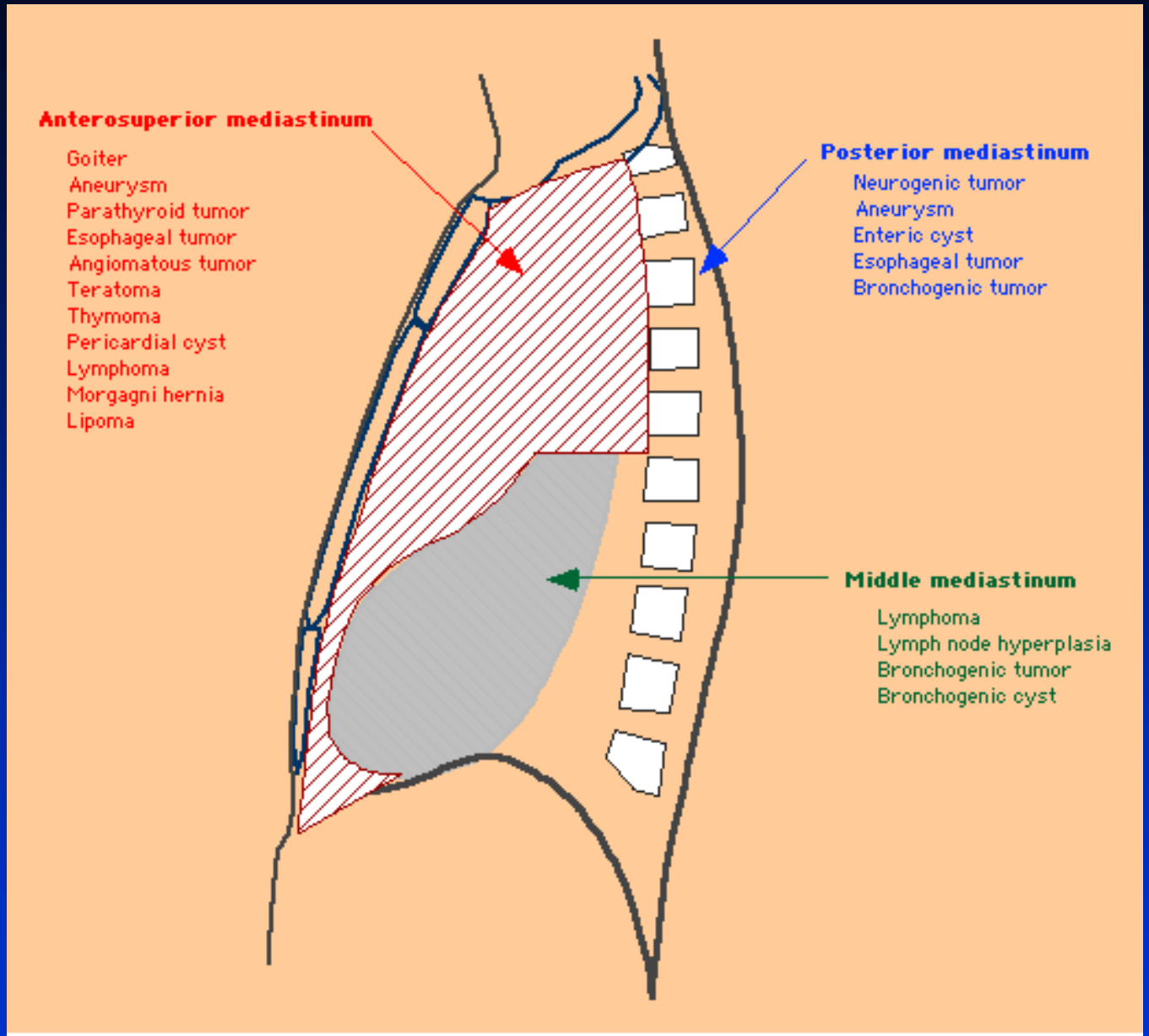
Thoracic Anatomy


The trachea (windpipe) carries air from your nose and throat to your lungs.
The bronchial tubes branch off from the trachea, carrying air to the lungs and to each lobe within the lungs.
Lobes are distinct sections of the lungs. They contain **alveoli** (tiny air sacs). Oxygen enters the bloodstream from the alveoli.
The chest wall is made up of ribs and muscles.
The pleural cavity is the space between the lungs and the chest wall.
Lymph nodes around your lungs filter fluid from your lungs and help your body defend itself against infection.
Right lung
Left lung
The mediastinum is the area that separates the two lungs.

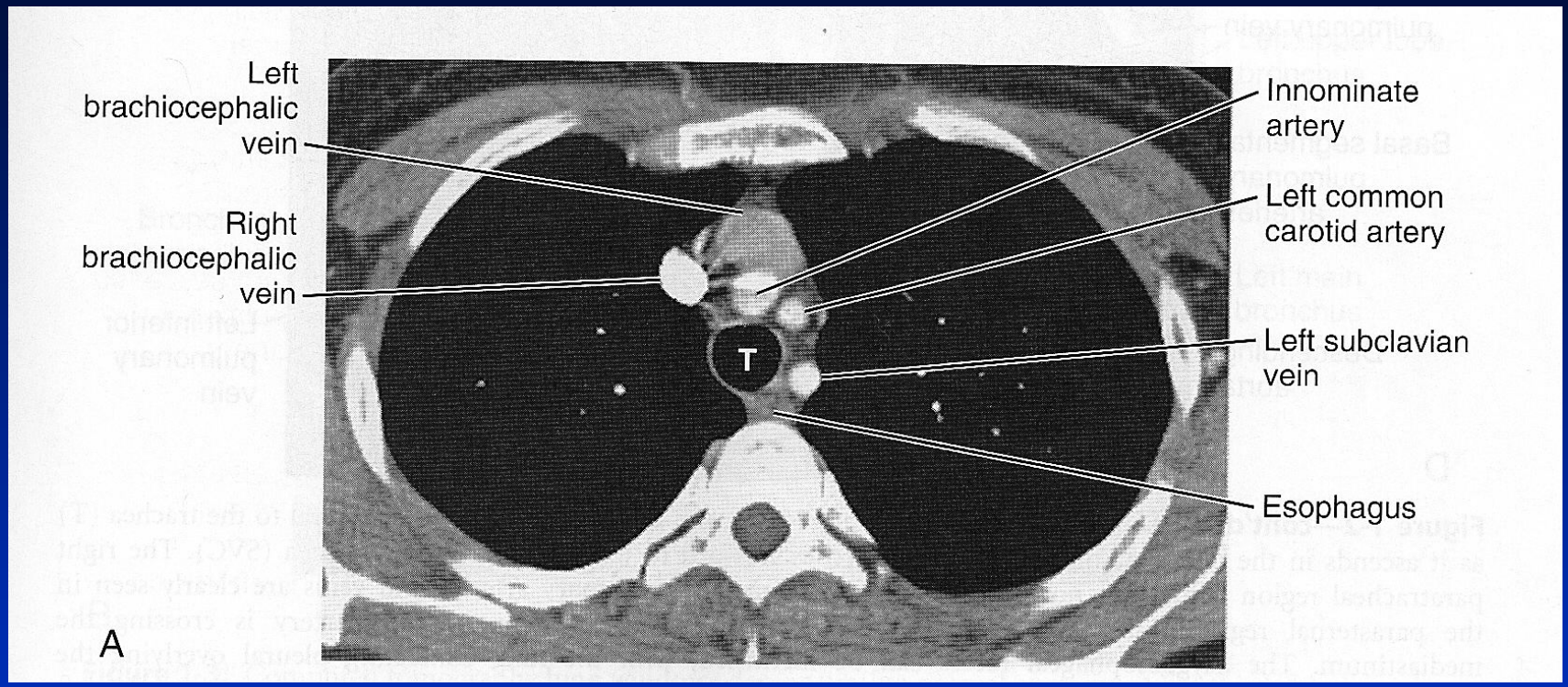

Right Pulmonary Artery
Left Pulmonary Artery
Main Pulmonary Artery
Apical Posterior Branch
Apical Posterior Branch
Ascending Branch of Right Pulmonary Artery
Anterior Branch
Anterior Branch
Descending Branch of Left Pulmonary Artery
Superior Branch
Superior Branch
Superior Lingular Branch
Descending Branch of Right Pulmonary Artery
Inferior Lingular Branch
Middle Lobe Branches
Lateral Basal Branch
Lateral Basal Branch
Anterior Basal Branch
Pulmonary Valve
Posterior Basal Branch
Medial Basal Branch
Posterior Basal Branch
Anteromedial Branch

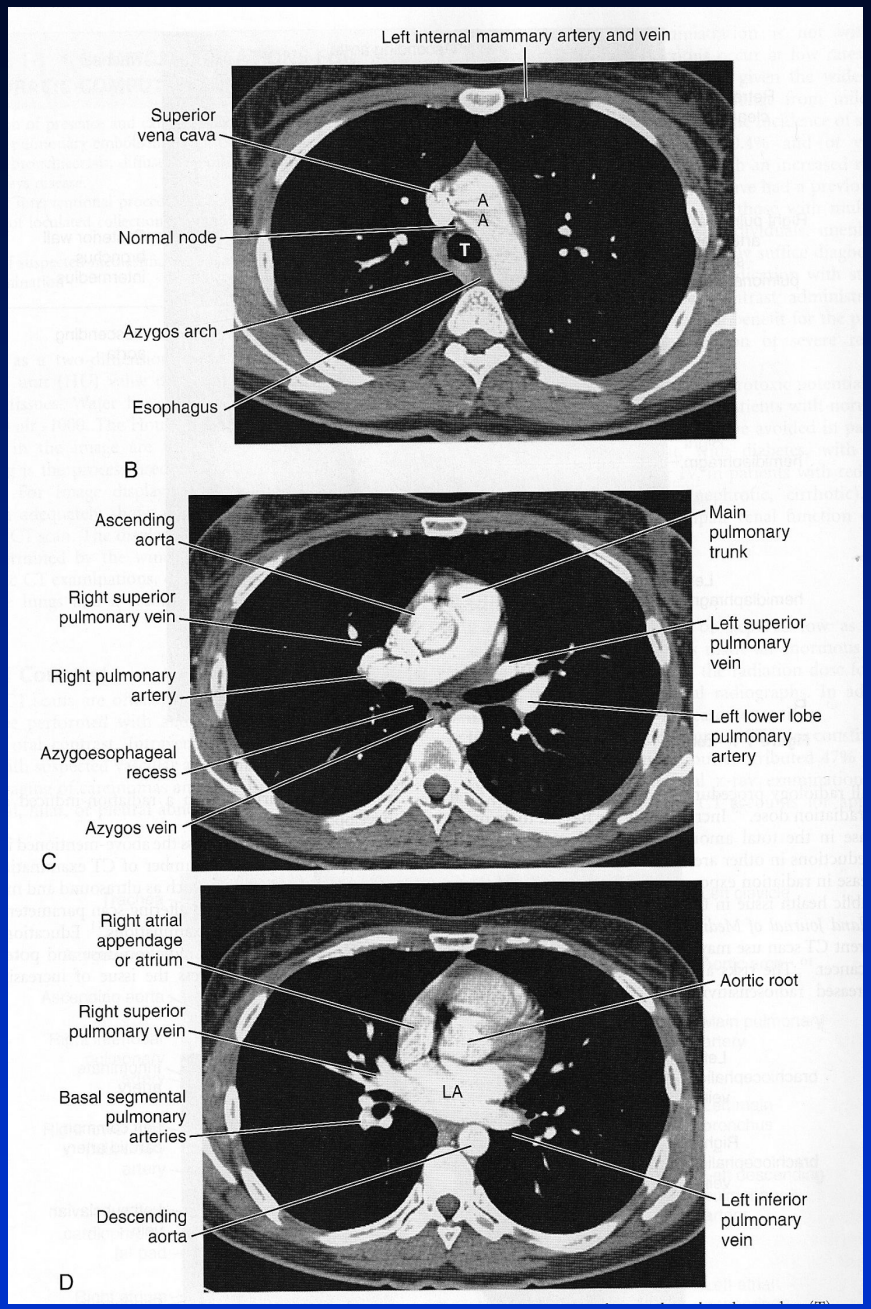

Left Atrium
Right Superior Pulmonary Vein
Left Superior Pulmonary Vein
Left Inferior Pulmonary Vein
Right Inferior Pulmonary Vein


Right main stem bronchus
Right lobes
Trachea
Left main stem bronchus
bronchi
Bronchioles
Left lobes
Pleura
Pleural fluid
Diaphragm
Alveoli



Common diagnostic possibilities of mediastinal masses The differential diagnosis of a mediastinal mass depends upon the anatomic compartment in which it arises. Redrawn from Baue, AE, et al. Glenn's Thoracic and Cardiovascular Surgery. 5th ed. Appleton & Lange, Norwalk, CT,1991.


Left brachiocephalic vein
Right brachiocephalic vein
Innominate artery
Left common carotid artery
Left subclavian vein
Esophagus
T
A



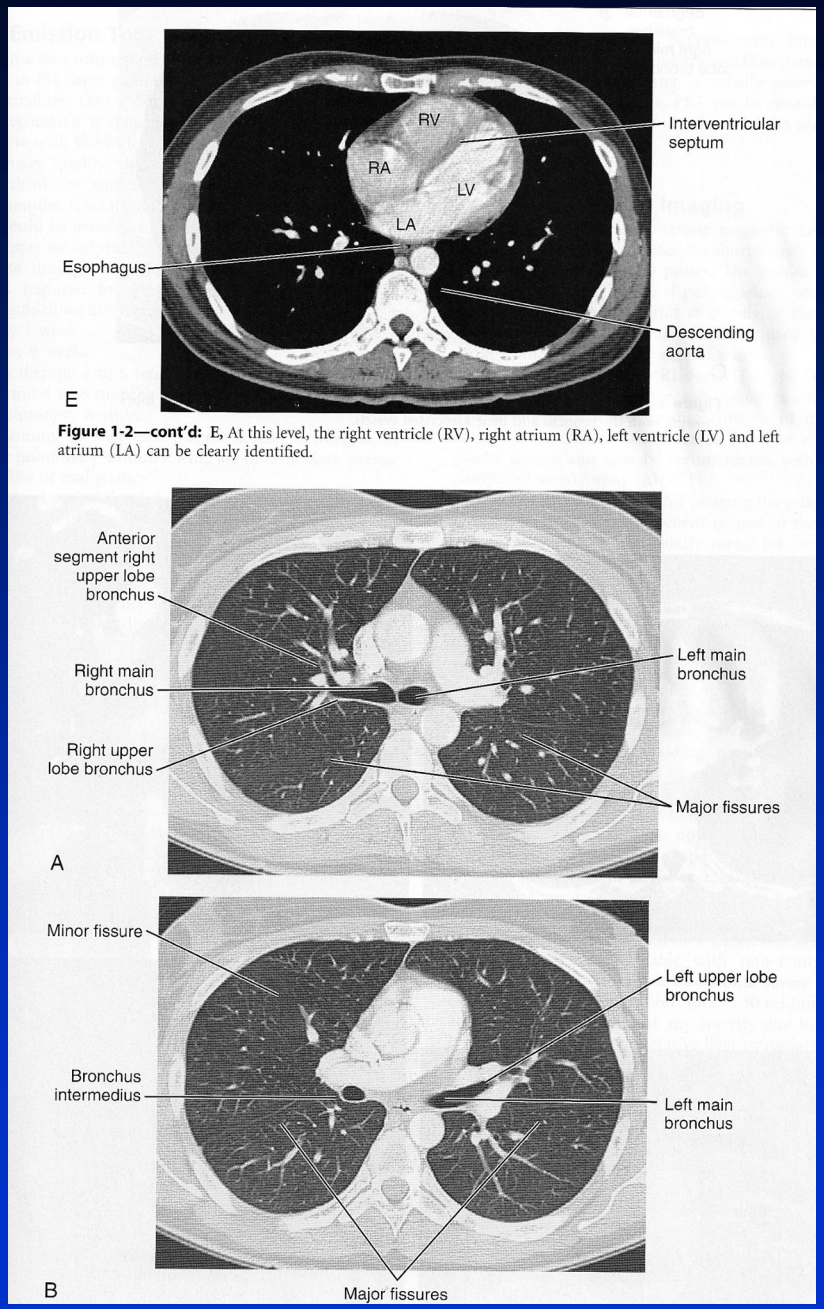
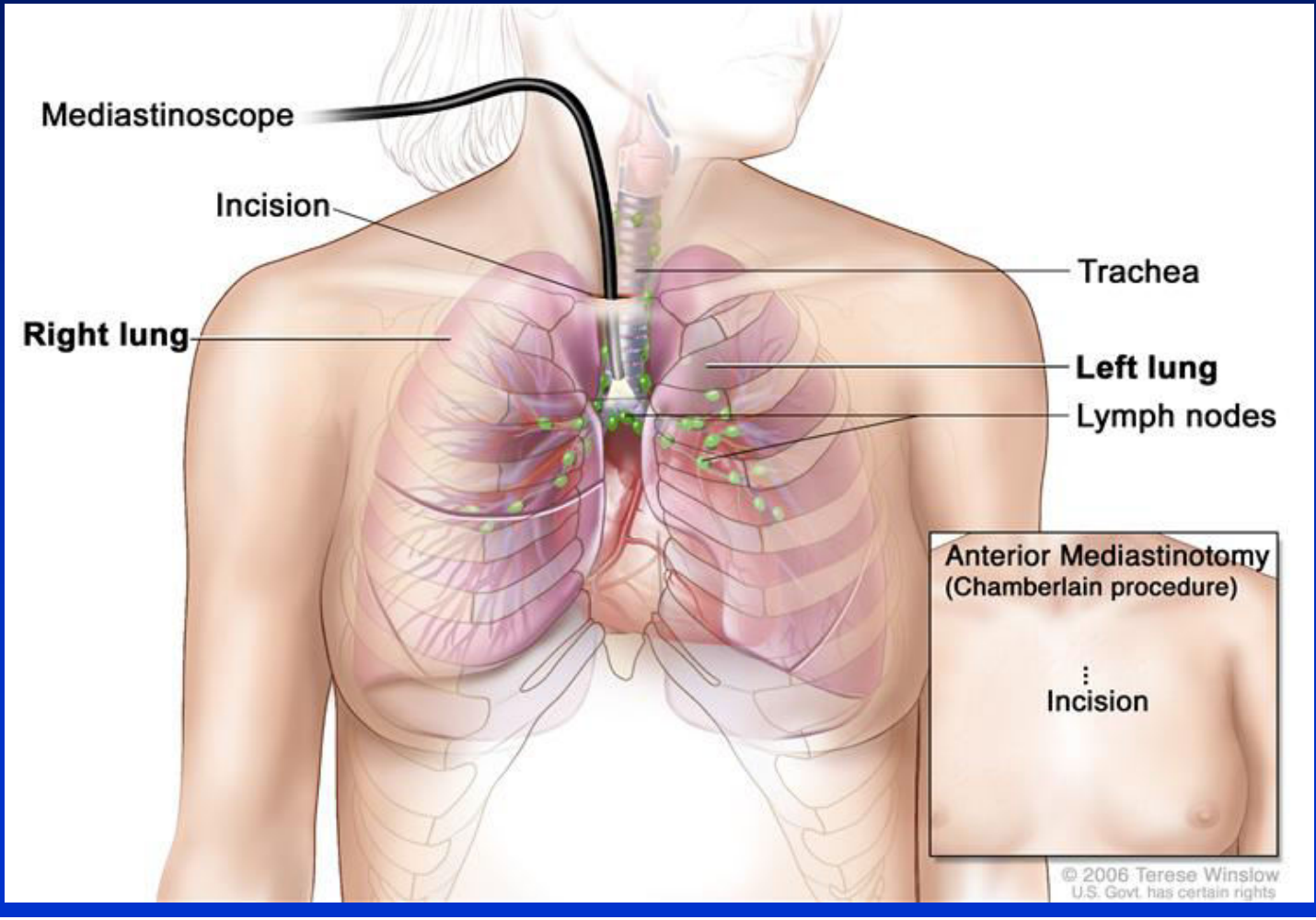
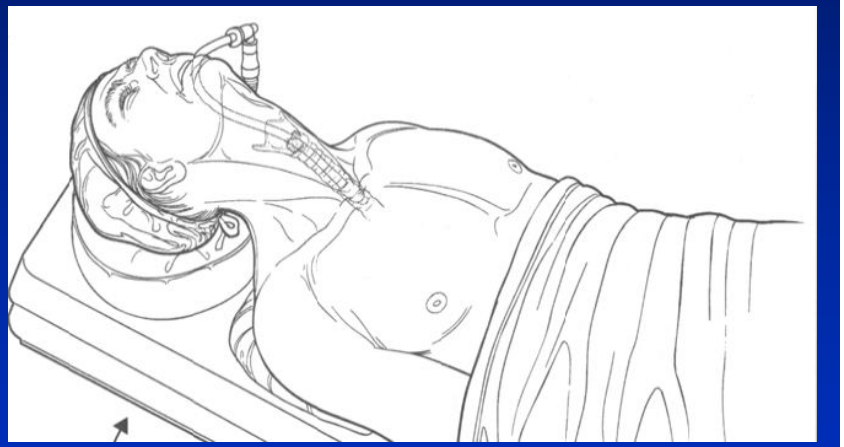


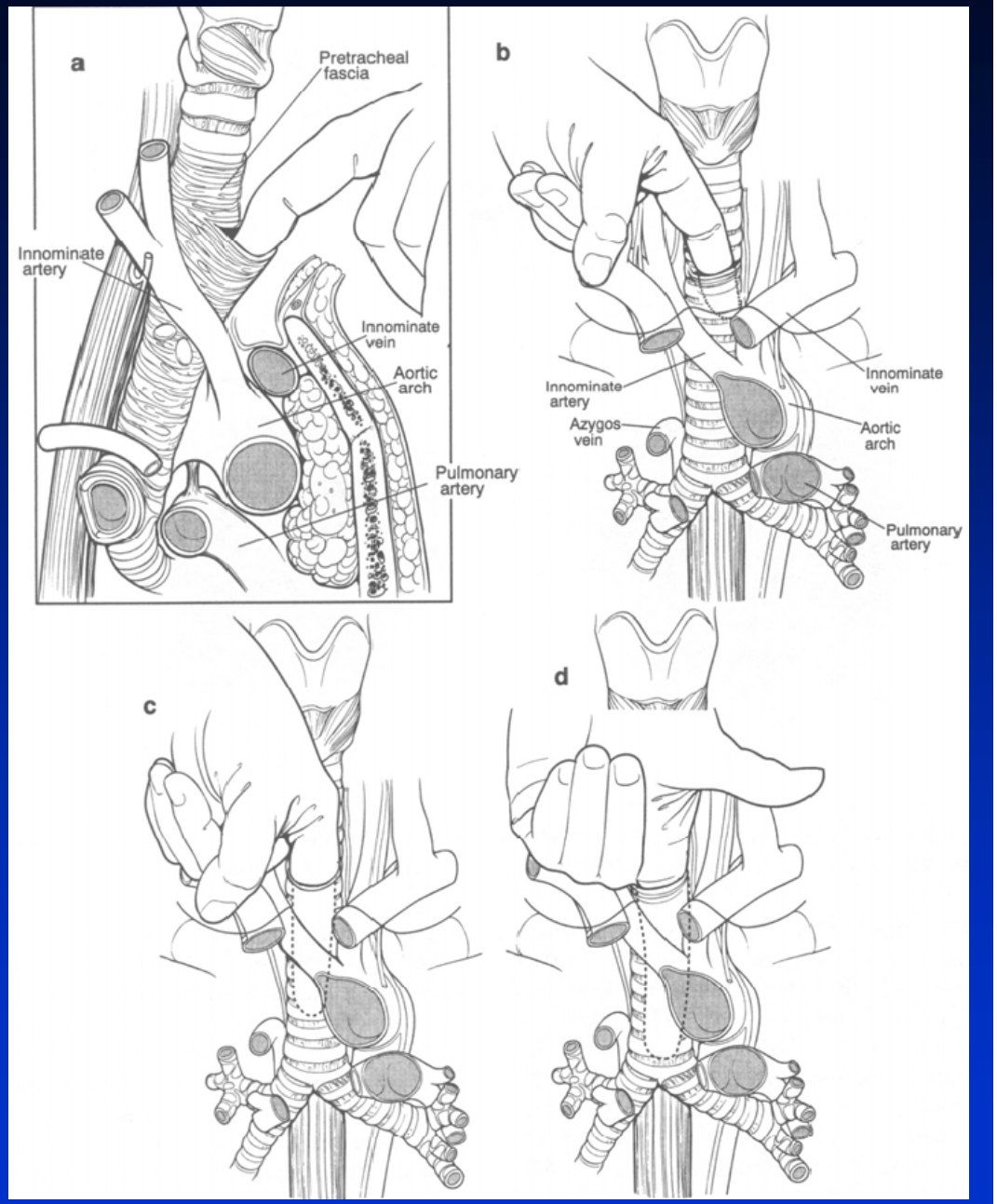
Figure 1-2—cont'd: **E,** At this level, the right ventricle (RV), right atrium (RA), left ventricle (LV) and left atrium (LA) can be clearly identified.

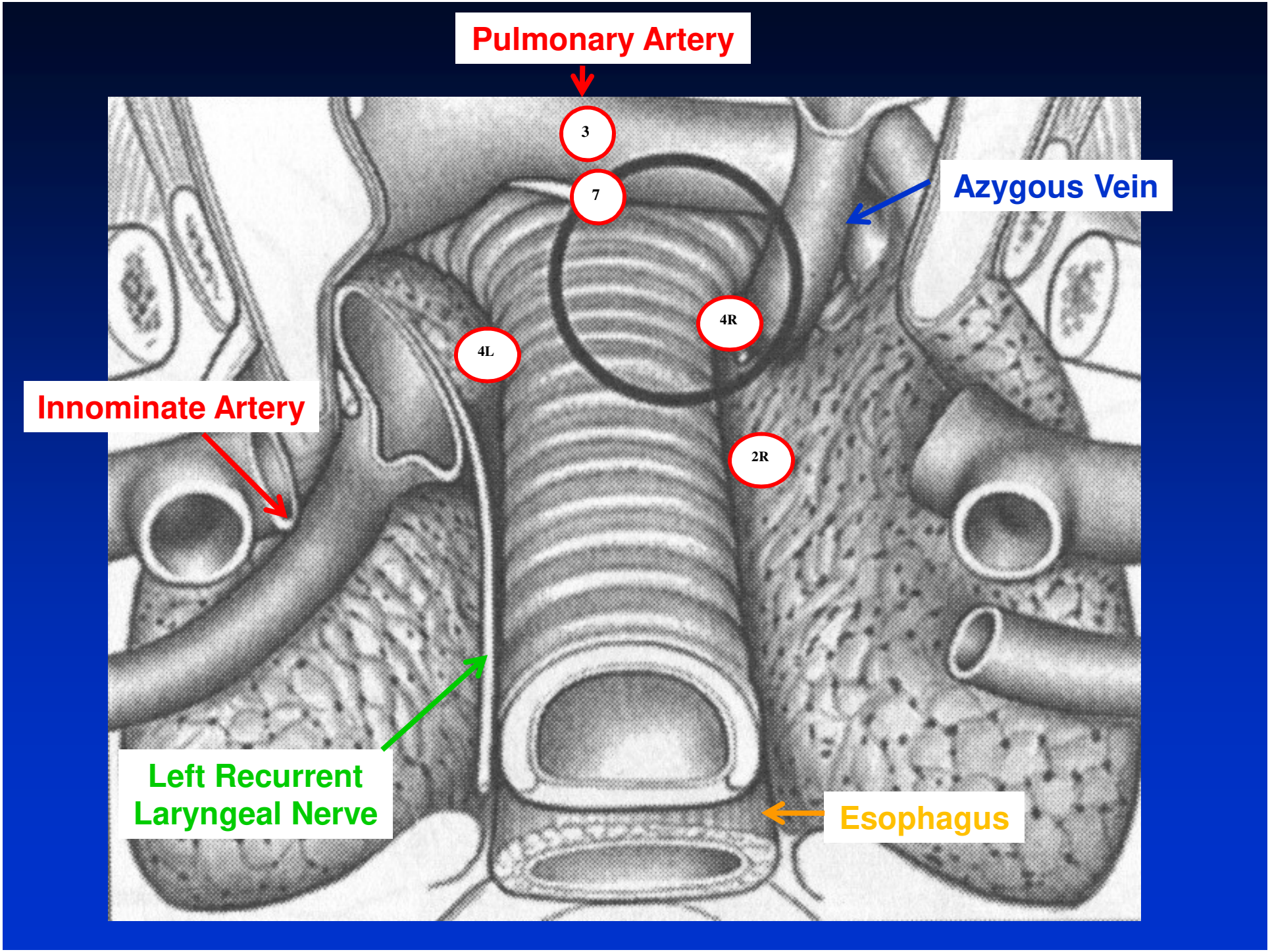
Thoracic Procedures

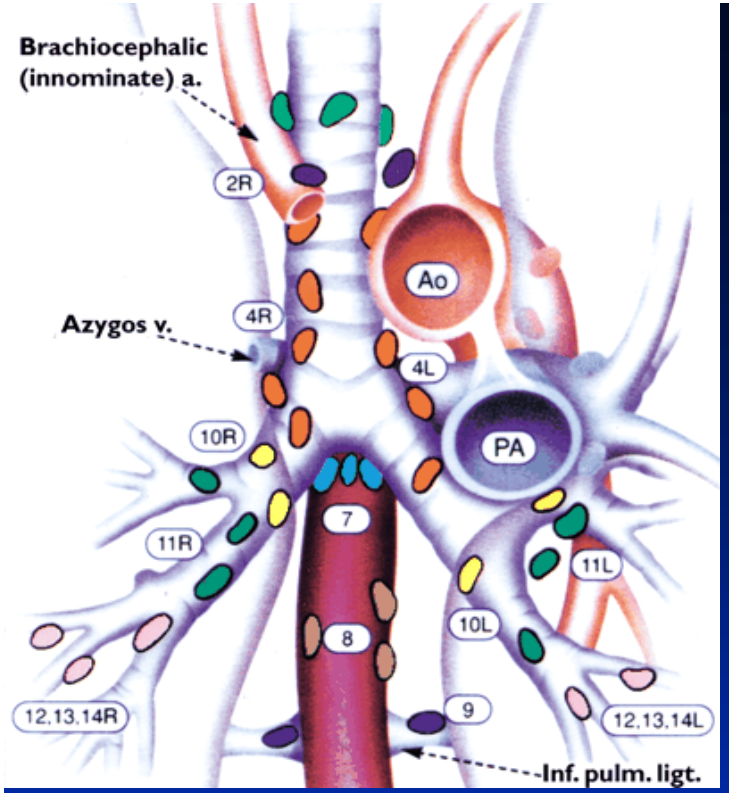
Mediastinoscopy is usually an outpatient procedure performed to sample lymph nodes alongside the trachea in the mediastinum. This is usually done to stage patients with lung cancer and is also useful to diagnose other neoplastic, granulomatous, and inflammatory causes of enlarged mediastinal lymph nodes.






a
Pretracheal fascia
Innominate artery
Innominate vein
Aortic arch
Pulmonary artery
b
Innominate artery
Azygos vein
Innominate vein
Aortic arch
Pulmonary artery
c
d


Pulmonary Artery
3
7
Azygous Vein
4R
4L
Innominate Artery
2R
Left Recurrent
Laryngeal Nerve
Esophagus



Superior Mediastinal Nodes

- 1 Highest Mediastinal
- 2 Upper Paratracheal
- 3 Prevascular and Retrotracheal
- 4 Lower Paratracheal (including azygos nodes)

N_2 = single digit, ipsilateral
N_3 = single digit, contratateral or supraclavicular

Aortic Nodes

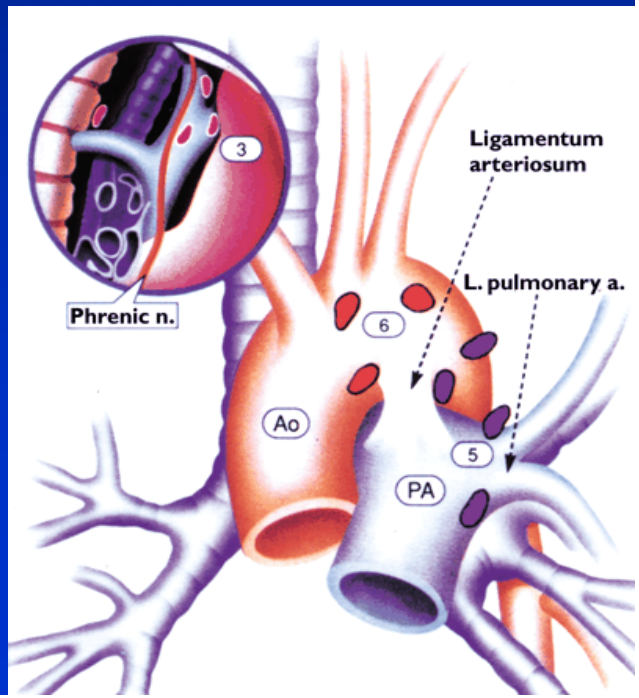
- 5 Subaortic (AP window)
- 6 Para-aortic (Ascending aorta or phrenic)

Inferior Mediastinal Nodes

- 7 Inferior Mediastinal Nodes
- 8 Paraesophageal (below carina)
- 9 Pulmonary Ligament

N_1 Nodes

- 10 Hilar
- 11 Interlobar
- 12 Lobar
- 13 Segmental
- 14 Subsegmental



Postoperative Care

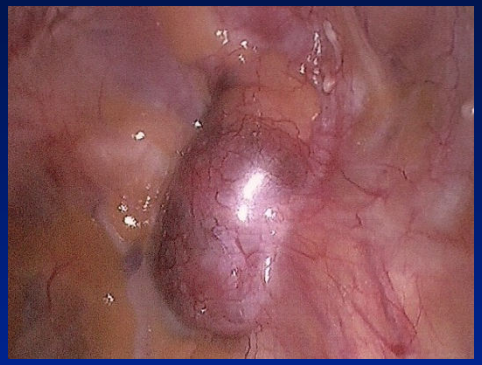
- Usually outpatient procedure, or performed on inpatients.
- Minimal postoperative pain.
- No limitations, advance diet as tolerated, and can resume anti-coagulants 24-48 hours later.

Pitfalls / Complications

- **Mortality: 0 – 0.5%**
- **Morbidity: 0.6% - 2.3%**

- **Massive Bleeding**
- ***What if:***
  - **Patient becomes profoundly septic, elevated WBC, fevers, and CT scan done shows air in mediastinum.**
  - **Patient on floor has white drainage from neck incision.**
  - **Patient on floor is hoarse and coughs every time he drinks or eats.**
  - **Patient has shortness of breath, decreased oxygen saturation, and diminished right breath sounds.**
  - **Patient wakes up and has weakness of his left arm or leg.**

Mediastinal Tumors



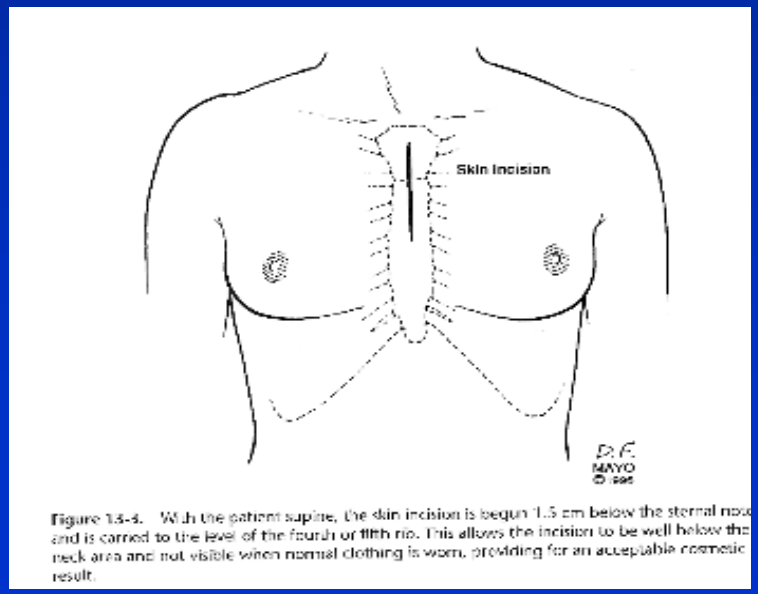
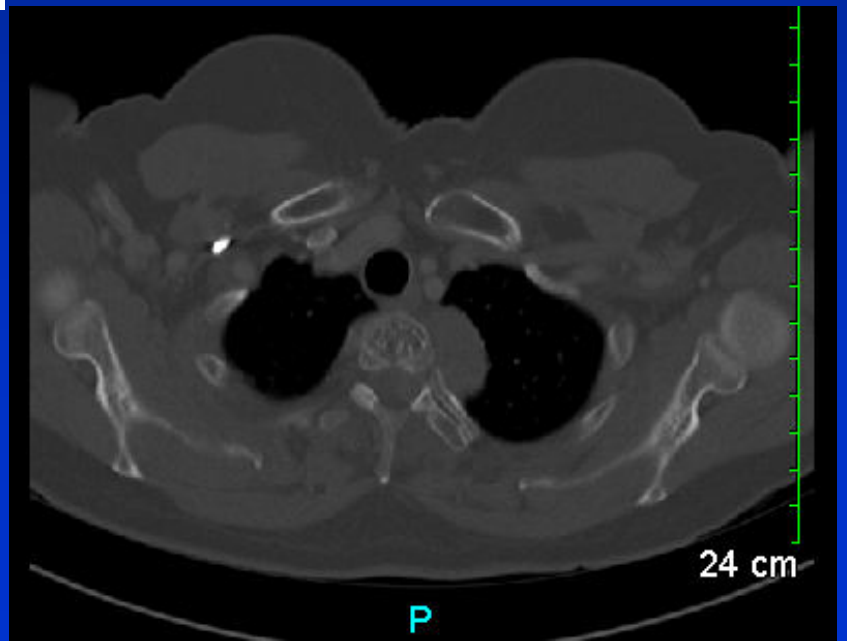


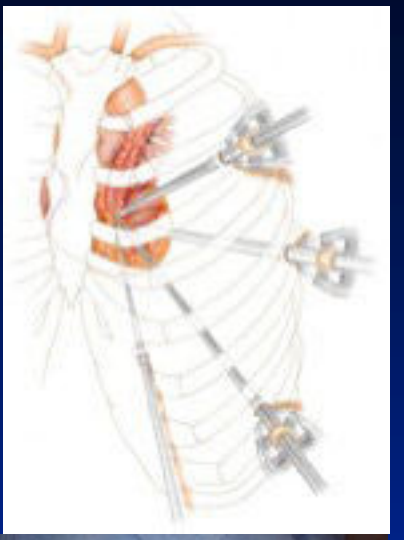
Figure 13-4. With the patient supine, the skin incision is begun 1.5 cm below the sternal notc
and is carried to the level of the fourth or fifth rib. This allows the incision to be well below the
neck area and not visible when normal clothing is worn, providing for an acceptable cosmetic
result.

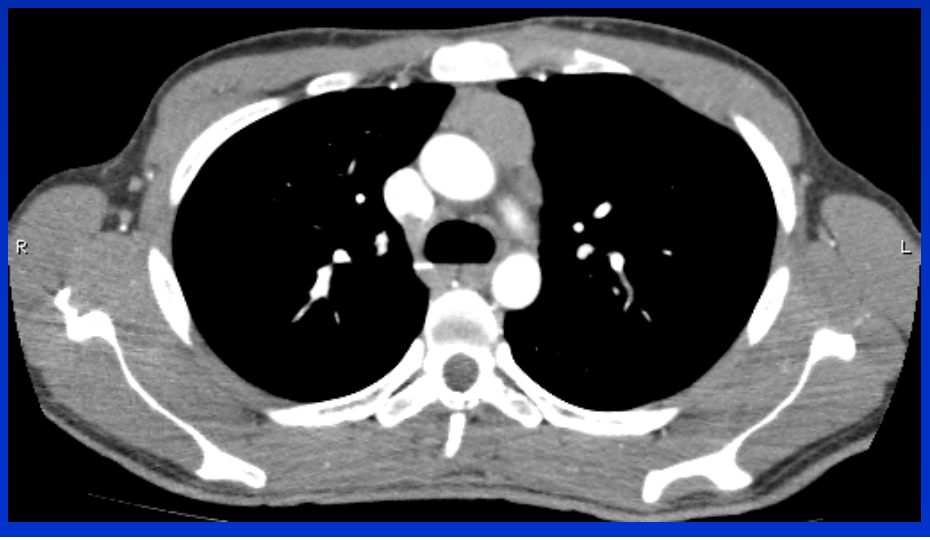


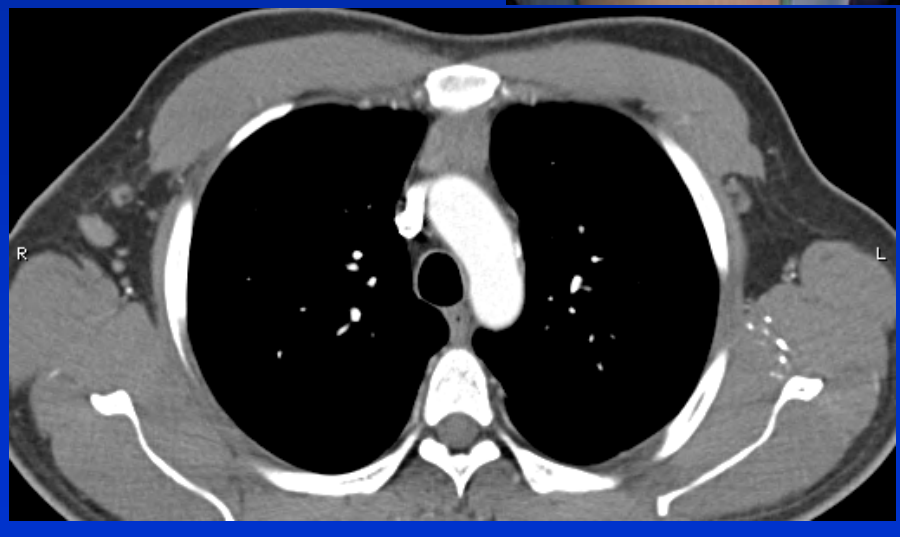
Thymectomy, or removal of the thymus, improves the symptoms in 80-90% of patients with myasthenia gravis. Also, thymectomy is indicated for tumors of the thymus gland and thymic cysts.

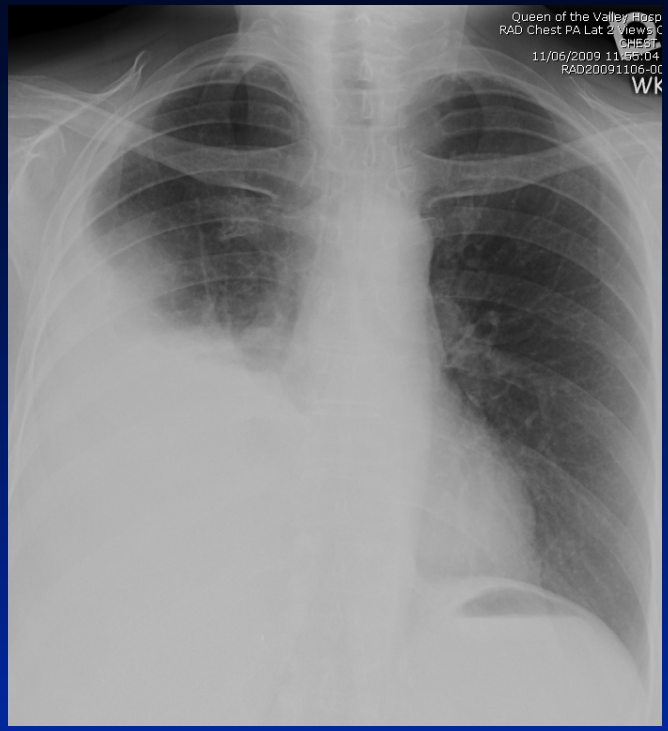
For thymomas related to myasthenia gravis, the thymus can be removed minimally invasively with a VATS or Robotic approach. This significantly reduces the hospital stay to 1-2 days, and allows faster recovery and return to work.

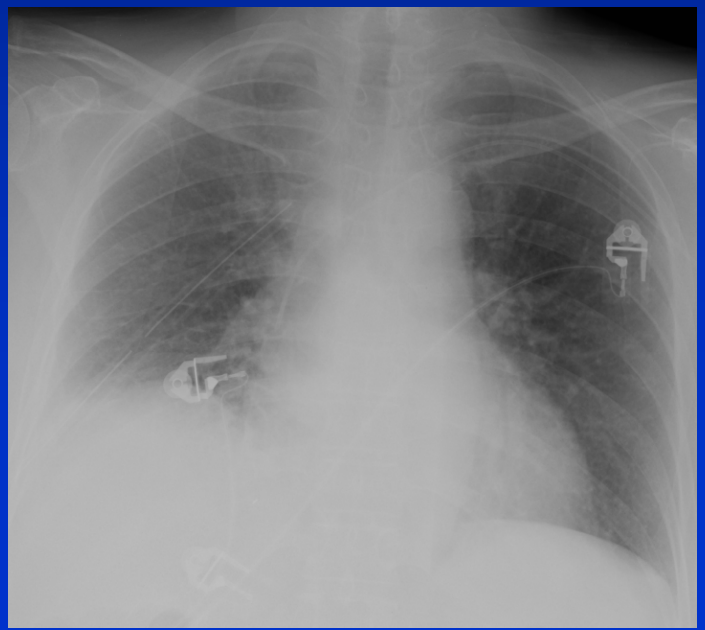
For thymic tumors, a median sternotomy approach is recommended and patients usually have a 4-5 day hospital stay.











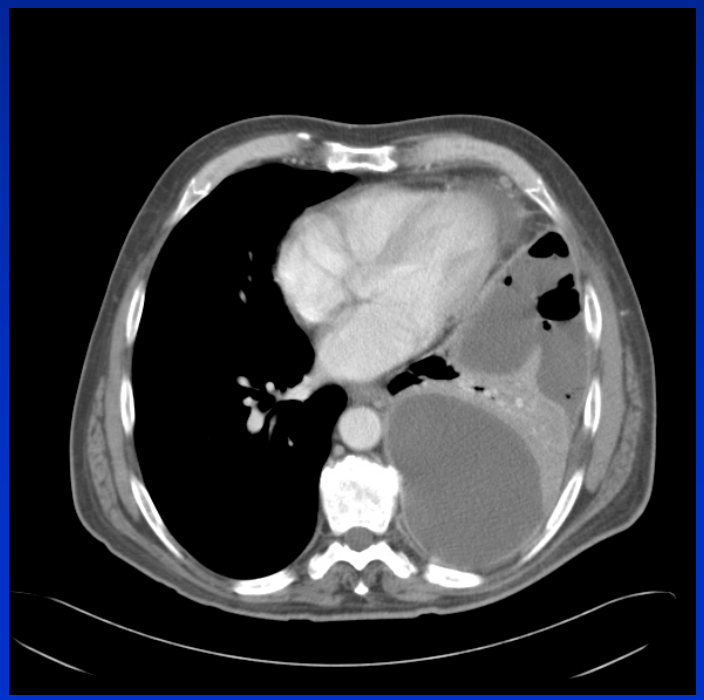
Pleura

Pleural biopsy is performed on patients to make a diagnosis and aid physicians to treat an underlying pleural process. Historically, the pleural biopsy was performed with an open incision, but currently we perform this procedure minimally invasively through VATS. Most patients describe minimal discomfort, and recover from the procedure in a day or two.

Pleural effusion is the accumulation of fluid in the chest or pleural cavity causing progressive compression of the lung and leading to shortness of breath. Malignant effusions are those secondary to lung cancer or metastatic cancers such as breast or ovary for example. The pleural effusion can be drained with a needle (thoracentesis) or chest tube (thoracostomy) but usually recurs and repetitive drainage causes discomfort, and loses efficacy over time.

A minimally invasive approach thru VATS can drain the fluid and instill talc powder to cause the lung to adhere to the chest wall (pleurodesis) and prevent re-accumulation of fluid. **VATS talc pleurodesis** is **90- 95% effective** and patients usually leave the hospital in 2-3 days after surgery.

Decortication

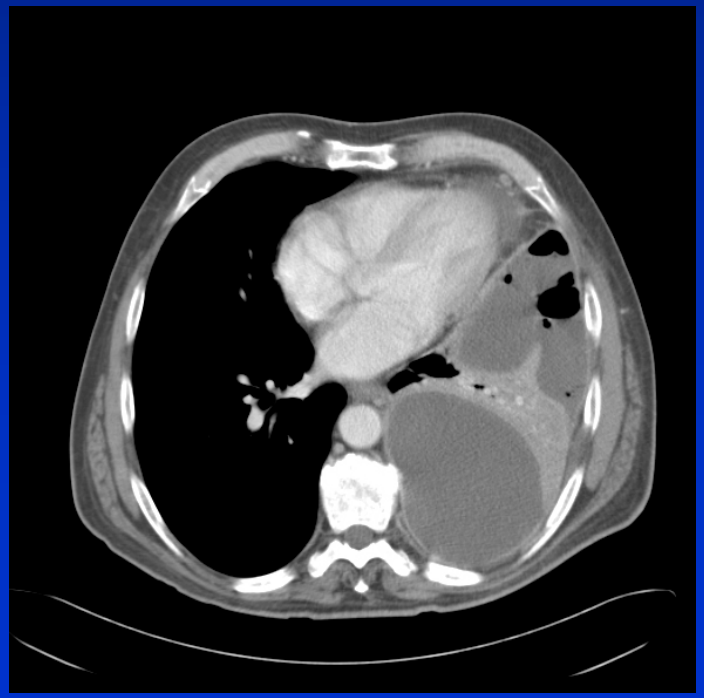


Empyema is pus in the chest or pleural cavity. It is usually the result of a bacterial pneumonia and subsequent parapneumonic effusion becoming secondarily infected. The **mortality rate** associated with empyema can be as high as **25-75%**.

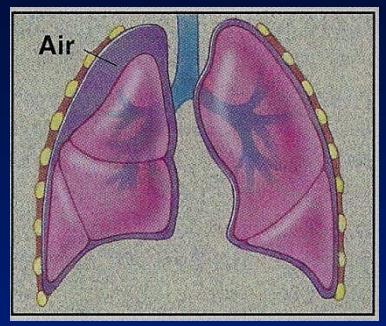
Surgical therapy with drainage of the effusion, removal of the pus and "peel" over the trapped lung is called **decortication** and is the most effective therapy, however it traditionally required a large thoracotomy and was not tolerated by elderly debilitated patients.

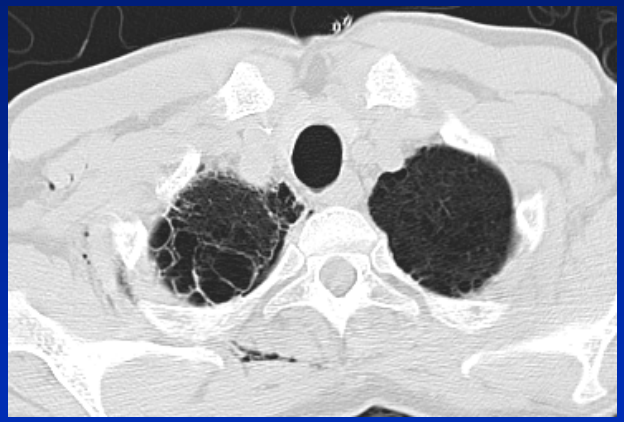
Today, decortication for empyema can be performed successfully using a **minimally invasive approach with VATS**. The VATS approach allows reduced hospital stay, faster recovery, and is an option for older sicker patients who would not otherwise be candidates for the more invasive traditional surgery.

Decortication



Spontaneous Pneumothorax





Spontaneous pneumothorax is an accumulation of air in the chest cavity causing lung collapse. It occurs in patients with no known lung disease and is attributed to rupture of small blebs on the surface of the lung. It usually occurs in thin, young males with cigarette smoking increasing its risk by 20 fold. Patients present with shortness of breath or pain on taking a deep breath.

Treatment varies from observation for a small pneumothorax, to chest tube placement for a larger pneumothorax. After the first episode there is a 30% chance of recurrence and after the second episode the recurrence rate is 70%. For this reason, surgery is recommended for recurrent spontaneous pneumothorax.

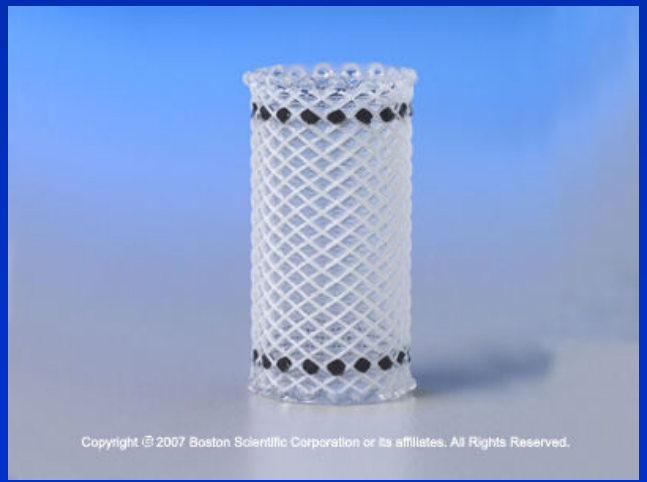
Surgery is done **minimally invasively with VATS** and entails resection of the blebs if present and pleurodesis (abrasion of the chest lining) to facilitate adhesion of the lung to the chest wall to prevent recurrences. Most patients are in the hospital for 2-3 days and return to full activity in a few weeks after surgery.

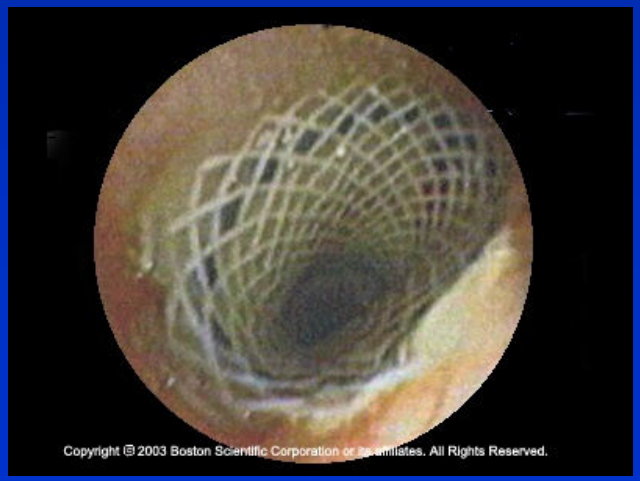
Airway Stents

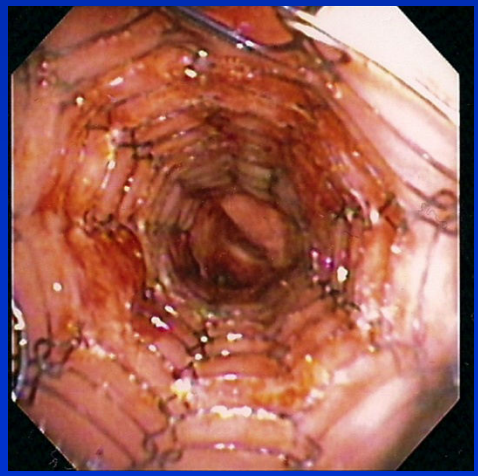
Airway stents are placed for several reasons: extrinsic compression from tumors, intrinsic obstruction from airway tumors, intrinsic stenosis, airway fistula, and tracheomalacia.

The airway stents are either silicone or metal with the metal stents coated or uncoated. Silicone stents can be removed later after placement while the metal stents are usually left in place.

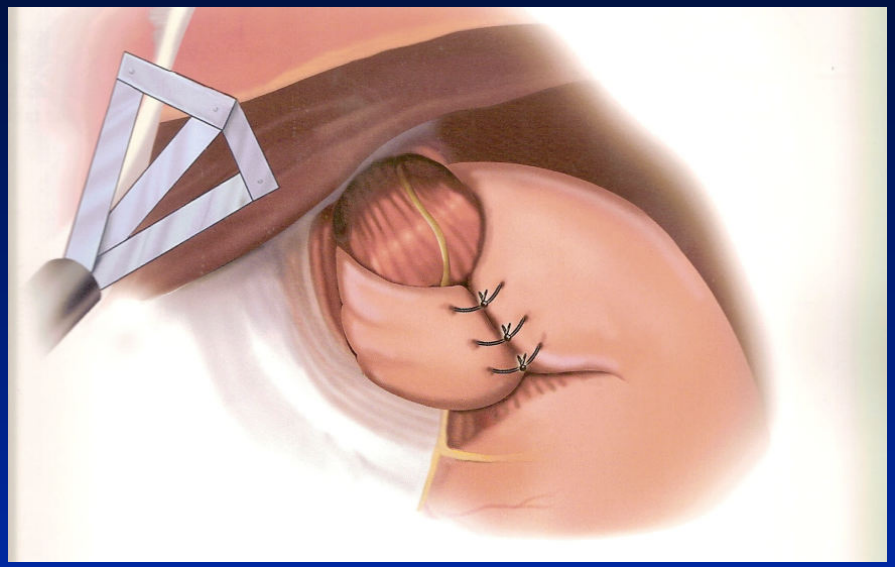
The stents are placed in the airway through a bronchoscope and the procedure usually is short and the patient can be discharged the following day.



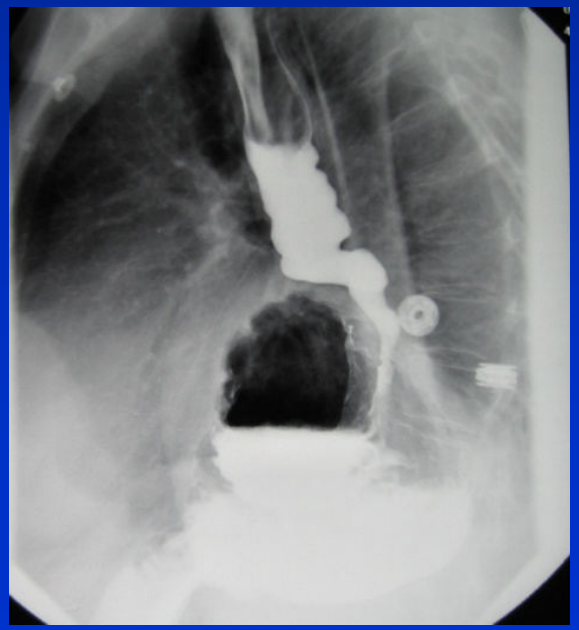




Esophageal Surgery



Laparoscopic Nissen repair for GERD involves 5 small incisions, use of a videoscope, and insufflations of CO2 gas. The repair involves reducing the esophagus into the abdomen, tightening the diaphragmatic crura with stitches, and performing a 360 degree wrap of the stomach around the distal esophagus to prevent acid reflux. Most patients are discharged home in 2-3 days, return to full activity by 6 weeks, and have no or minimal symptoms of reflux after surgery.



Paraesophageal hernias are uncommon and occur when the body of the stomach protrudes into the chest. Many are asymptomatic but can cause severe complications such as bleeding, obstruction, strangulation of the stomach, and perforation which could be lethal.

Surgery is the treatment of choice and was historically approached with either a large chest or abdominal incision. Currently, paraesophageal hernias can be repaired laparoscopically, reducing hospital stay and hospital complication rates. The repair involves reducing the stomach into the abdomen, resecting the hernia sac, closing the defect with mesh if necessary, and then fixing the stomach in the abdomen with either a gastrostomy feeding tube or wrapping the stomach (fundolipication).

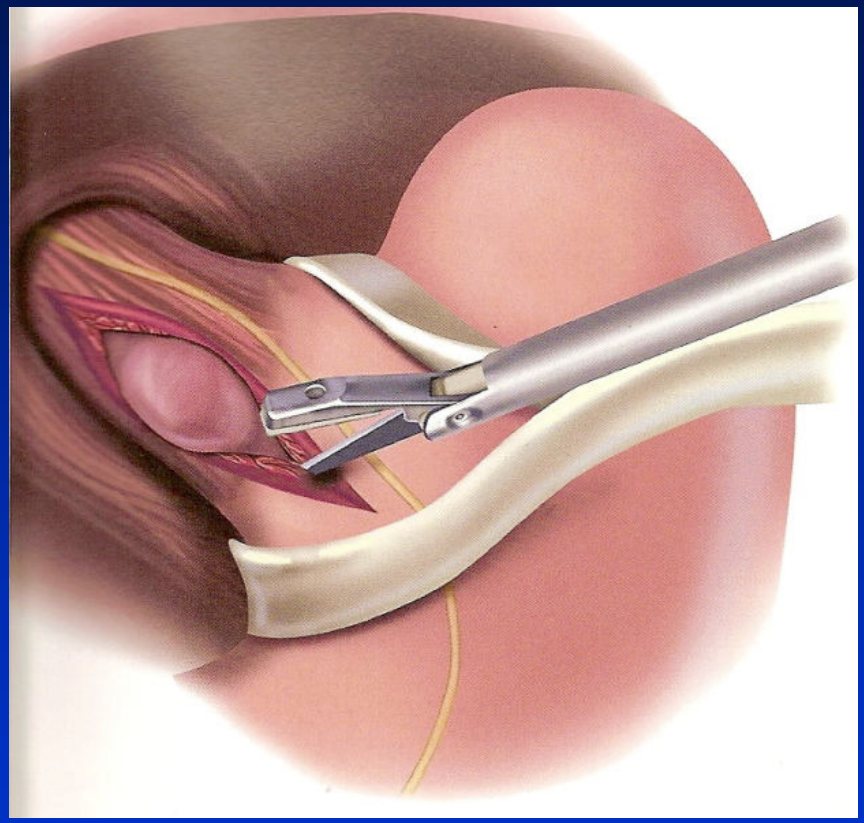
Heller Myotomy

Achalasia is a primary esophageal motility disorder that is characterized by failure of the esophagus to empty normally.

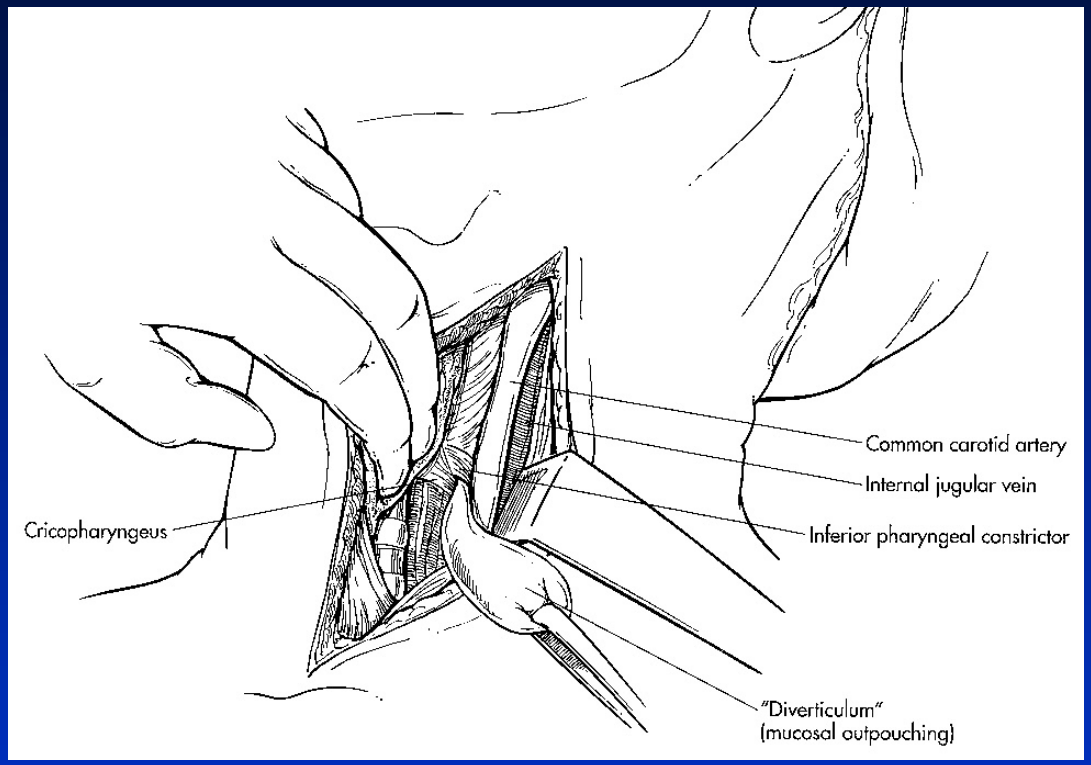
The cause is unknown and treatment is directed at relieving the outflow obstruction caused by failure of the lower esophageal sphincter to relax.

Treatment options include Botox injection, balloon dilation, and surgical myotomy, or dividing the offending esophageal muscle.

Surgical **Heller myotomy** is the gold standard treatment for Achalasia and when done minimally invasively, including robotically, has excellent results with average hospital stays of 1-2 days.



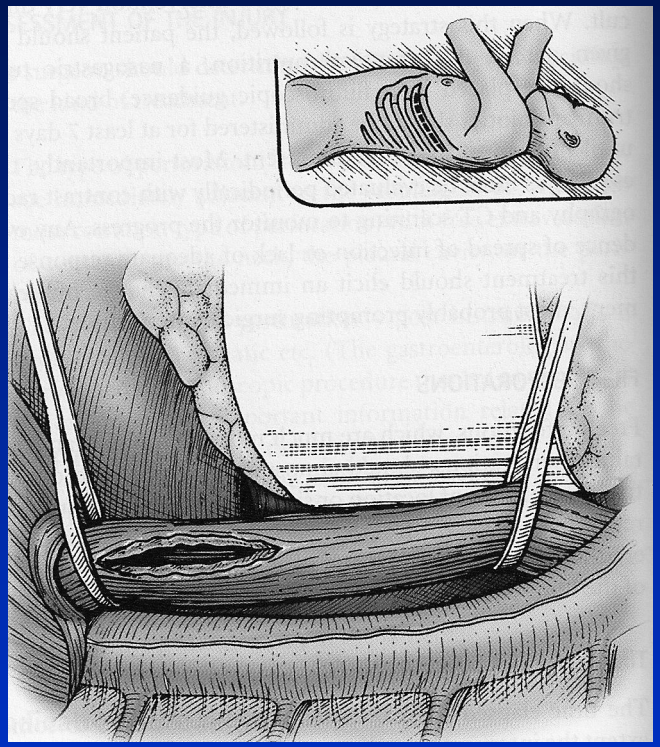
Zenker's Diverticulum



A **Zenker's diverticulum** forms as a result of dysfunction of the pharyngoesophageal junction. This leads to increased pressure that causes an outpouching of the esophagus, usually on the left side. The diverticulum that forms can then lead to food or pills getting stuck, cause bad breath, cause difficulty with swallowing, and lead to aspiration pneumonias. Once detected it should be repaired surgically.

The operation involves an incision in the left neck to divide the offending pharyngoesophageal muscle and then to either resect or suspend the diverticulum to prevent further complications. Most patients are discharged home in 2-3 days and have resolution of their symptoms after surgery.

Esophageal Perforation

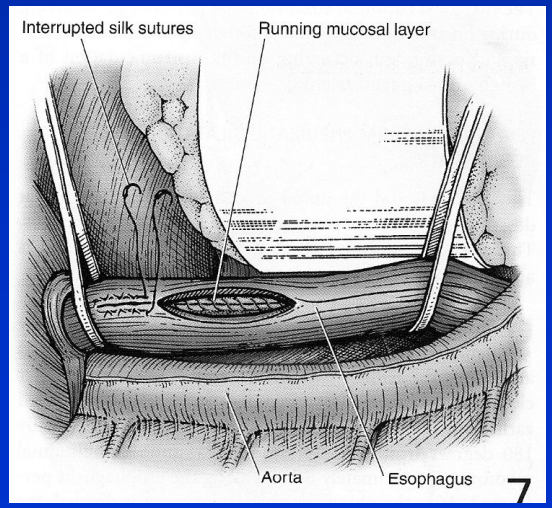


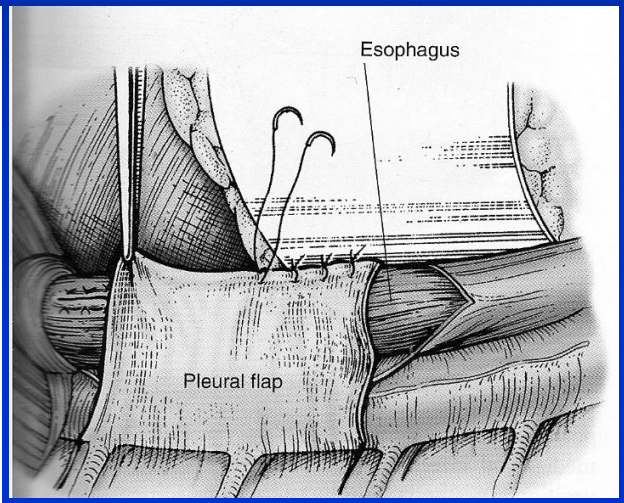
Esophageal perforation is a serious condition that if left untreated is usually fatal. The most common cause is related to esophageal instrumentation with scopes or dilation. Other causes include forceful vomiting, and obstructing esophageal tumors.

The consequence of perforation is the extravasation of oral secretions with bacteria into the mediastinal space leading to a severe inflammatory reaction and eventually septic shock and then death.

The most important factor in survival is the time from perforation to treatment – the sooner it is treated the better.

Treatment includes intravenous antibiotics, drainage with chest tubes and nasogastric tubes, and operative intervention. Surgical options include operative drainage, repair of the perforation which is preferred if possible, esophageal resection, and esophageal diversion.





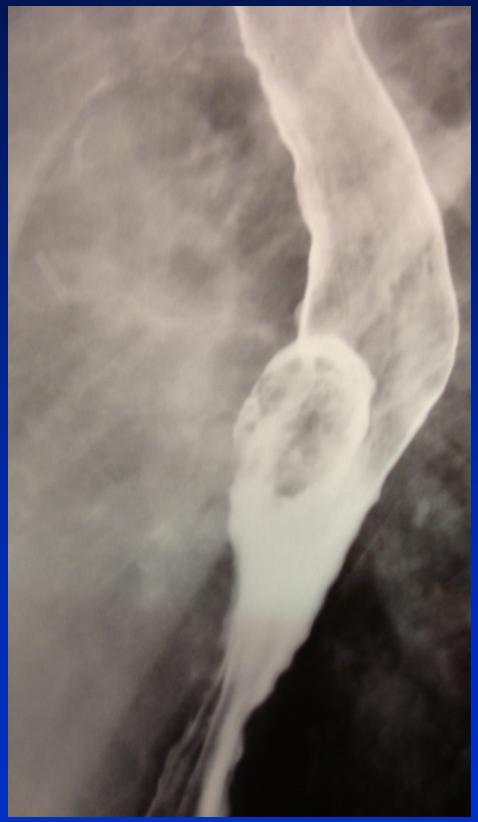
Esophageal Cancer

Esophageal cancer affects approximately 14,000 Americans each year with unfortunately an overall poor 5 year survival.

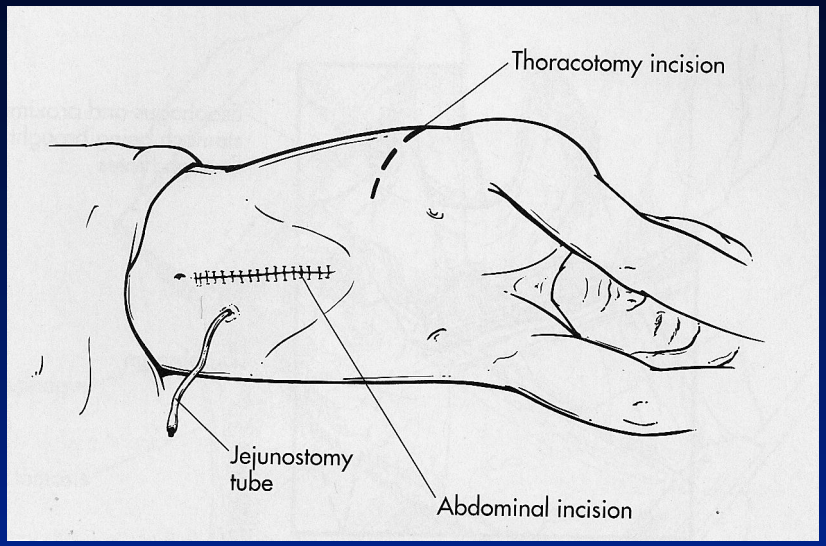
Most patients present with dysphagia, or difficulty swallowing. Diagnosis is usually made with a barium swallow, endoscopy with biopsy, and/or a CT scan.

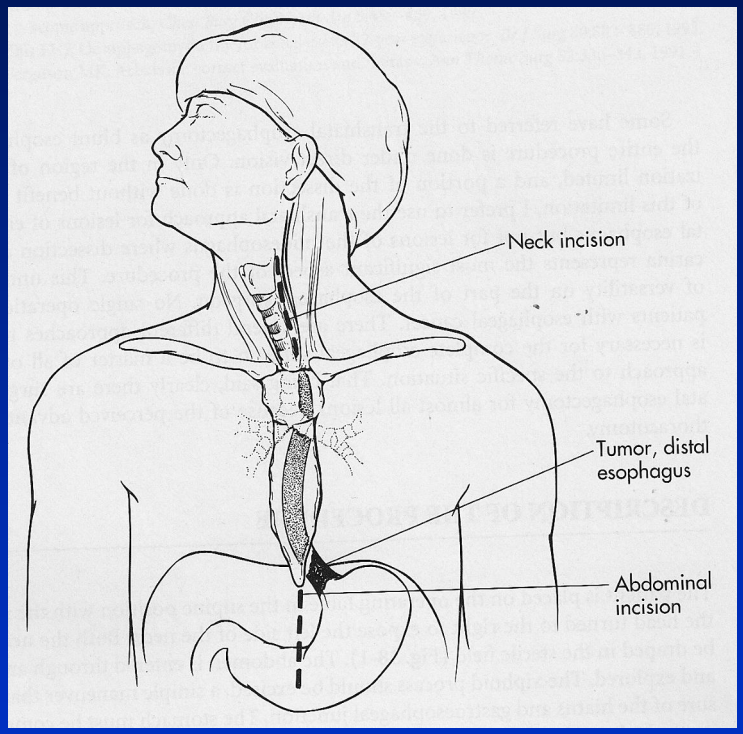
Surgery is directed at removing the esophagus and then replacing it with either the stomach or colon to re-establish gastrointestinal continuity.

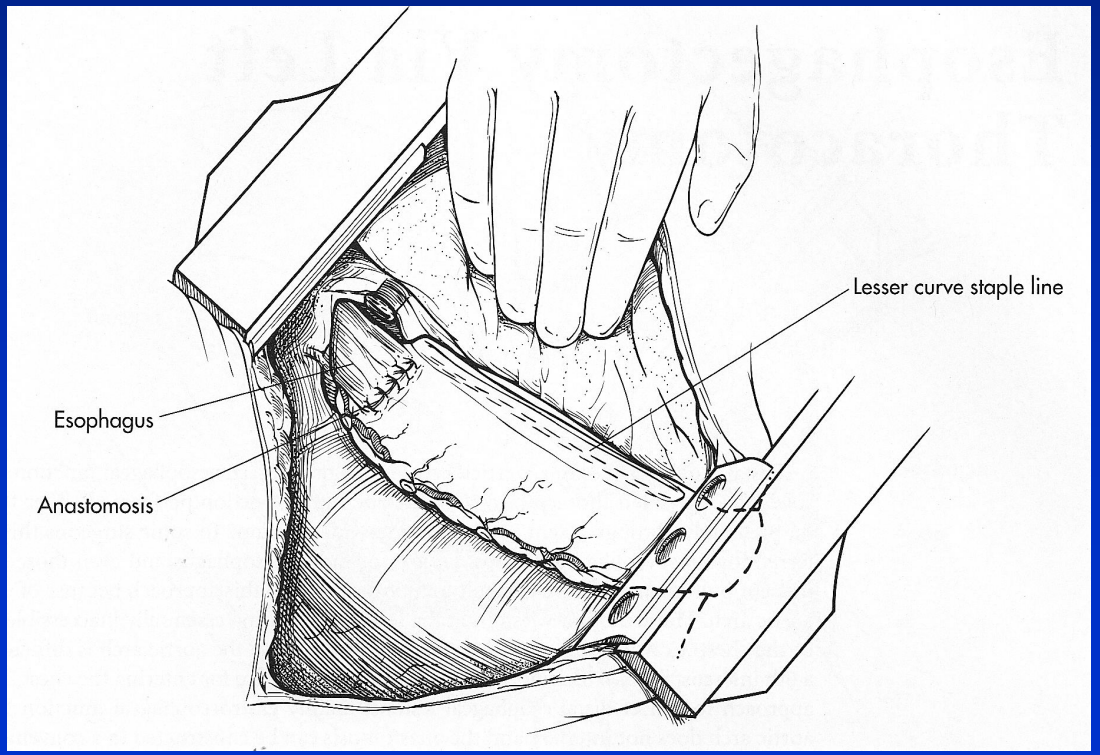
Traditionally, surgery involved either a large chest or abdominal incision or both, but now this can be accomplished minimally invasively. Most patients after undergoing an esophagectomy will stay in the hospital 10-14 days. The minimally invasive approach allows less postoperative pain, shorter hospital stays, and faster recovery.



Esophageal Cancer

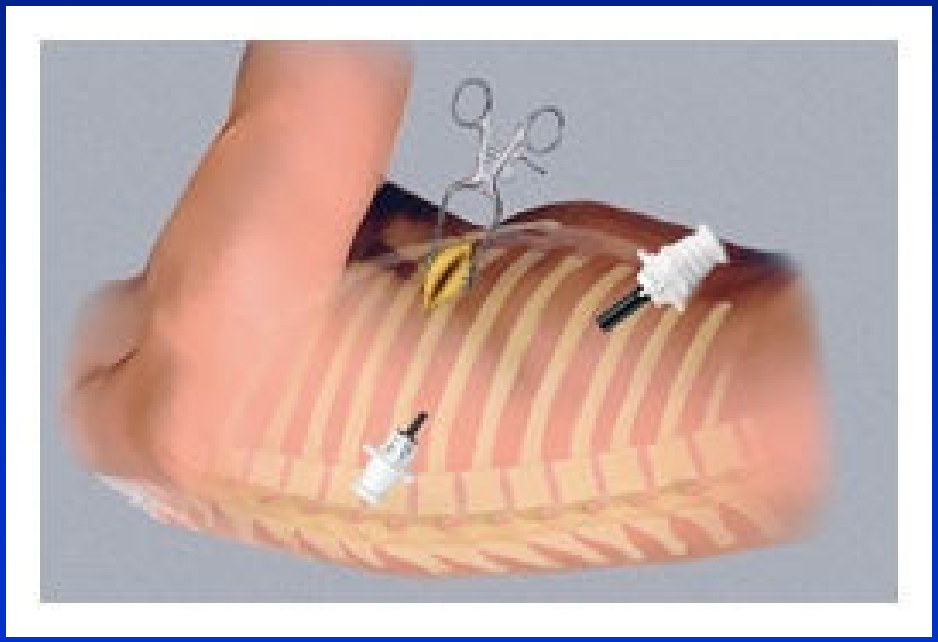


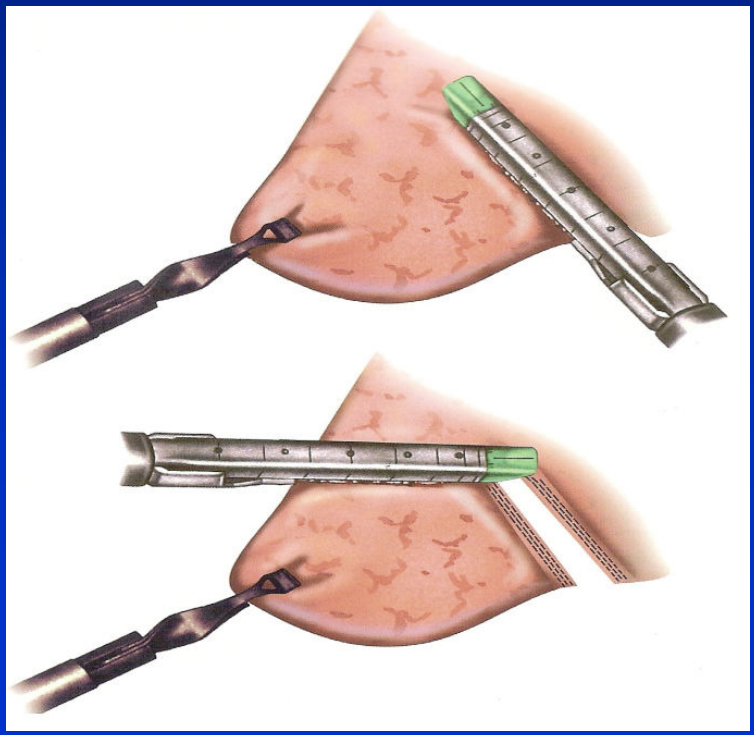




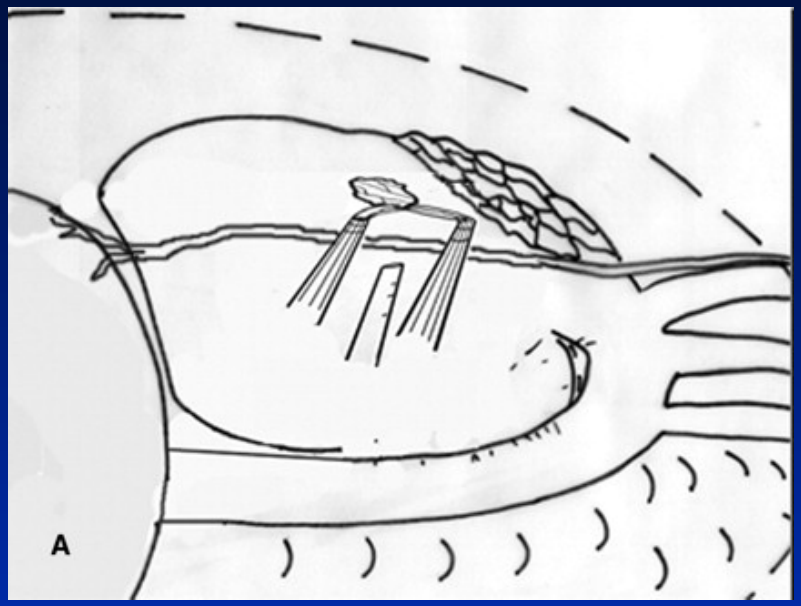
VATS
(Video Assisted Thoracic Surgery)

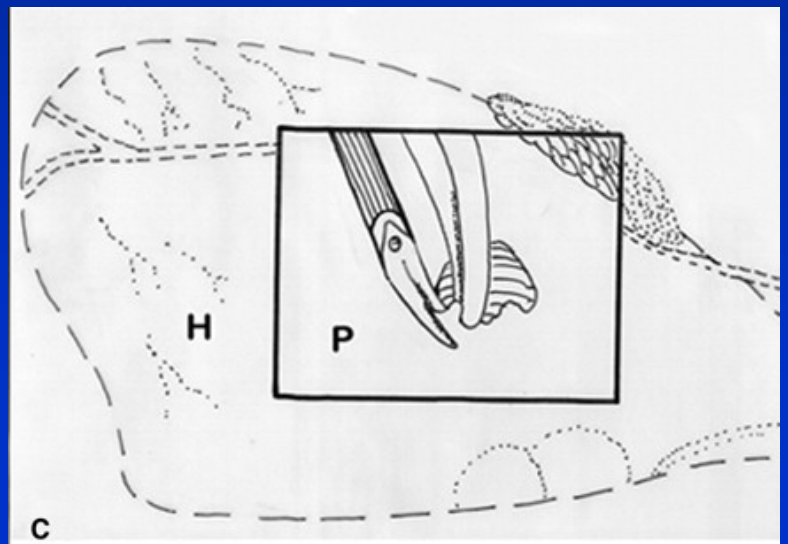

Example of VATS Incisions





Pericardial Window





Rocco et al, *J Thorac Cardiovasc Surg* 2006;131:921-922

Pericardial effusions if large enough it can cause tamponade, preventing the heart from filling properly and leading to death. The traditional approach of a subxyphoid pericardial window is 80-85% effective.

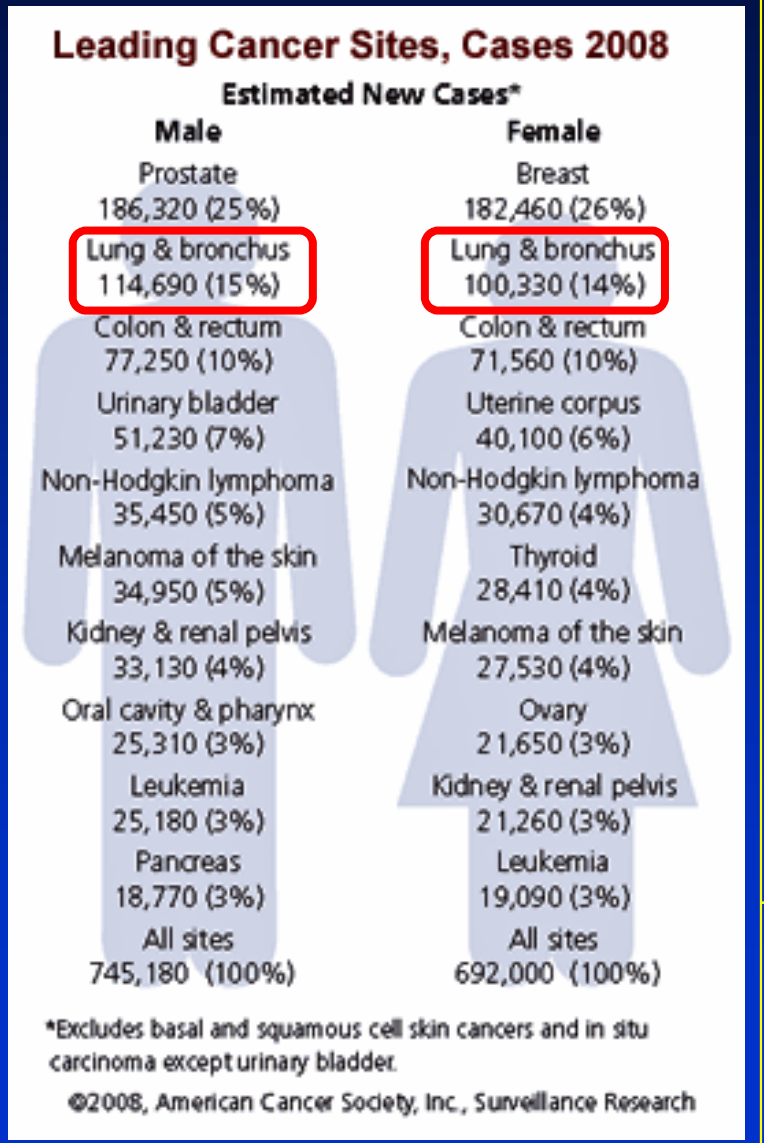
A **VATS pericardial window** is a minimally invasive video assisted approach that creates a hole in the pericardium to allow the fluid to drain into the chest cavity and is **95% effective** in draining the pericardial effusion and preventing cardiac tamponade.

TABLE 6-4 ■ RATES OF CONTROL FOR PERICARDIAL EFFUSION AFTER THE VARIOUS METHODS FOR TREATMENT[17]

Technique	No Recurrence at 3 Months (%)
Pericardiocentesis	10
Pericardiocentesis plus sclerosis	75
Subxiphoid window	86
Thoracotomy for window	90
VATS window	95

Lung Cancer

US Epidemiology



- 215,020 new cases in the US in 2008
  - 114,690 in men
  - 100,330 in women
  - Accounts for 15% of all new cancer cases
  - Average age at diagnosis is 71
  - Lifetime risk is 1 in 13 for men and 1 in 16 for women
- 161,840 deaths in the US in 2008
  - 90,810 men
  - 71,030 women
  - Accounts for 29% of all cancer deaths

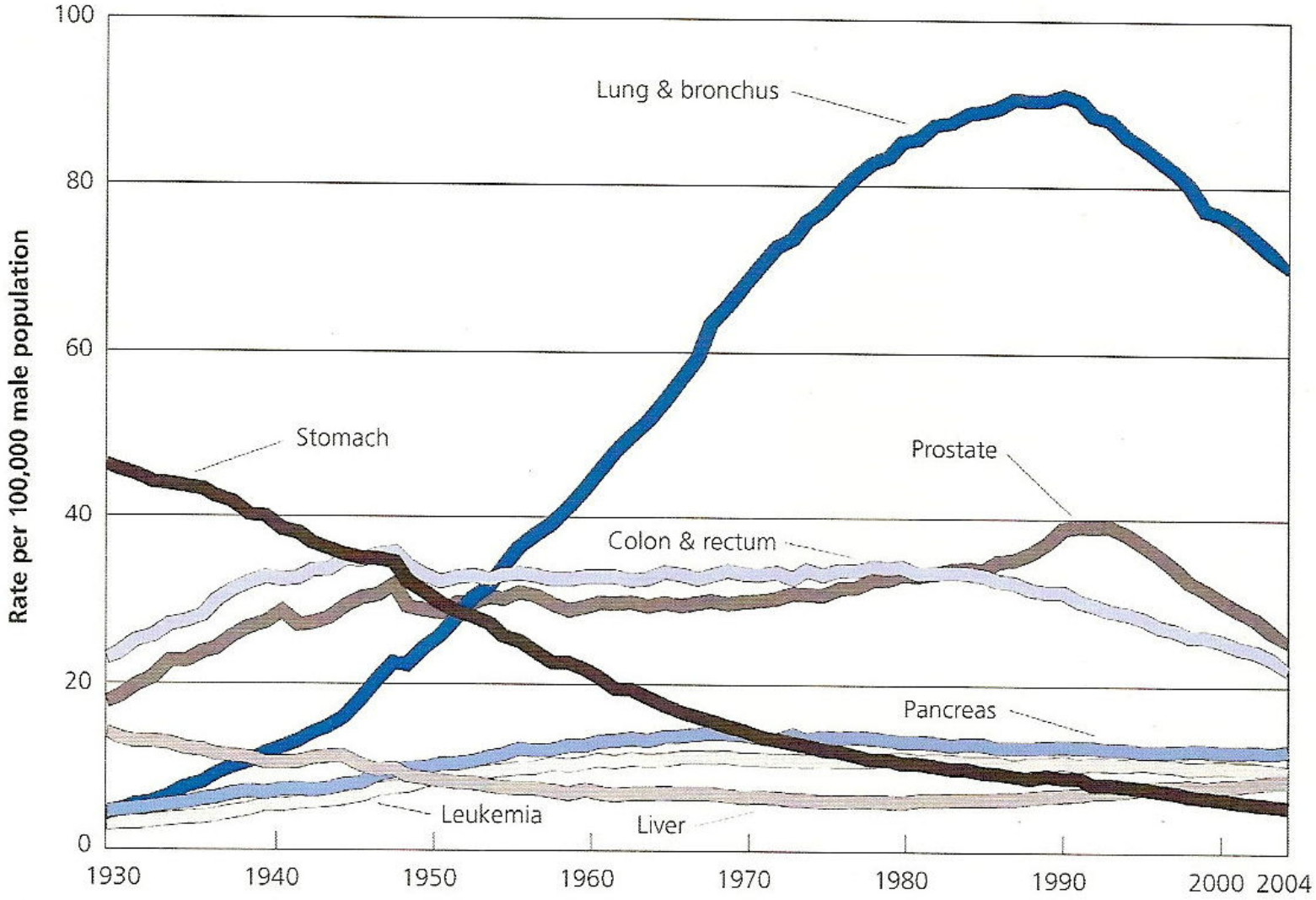
Lung cancer is the leading cause of cancer death for both men and women

More people die of Lung cancer than of Colon, Breast, and Prostate cancers COMBINED!

Lung Cancer Deaths in 2008
161,840

Colon Cancer Deaths =	49,960
Breast Cancer Deaths =	40,480
Prostate Cancer Deaths =	28,660
Combined Cancer Deaths =	119,100

Age-Adjusted Cancer Death Rates,* Males by Site, US, 1930-2004



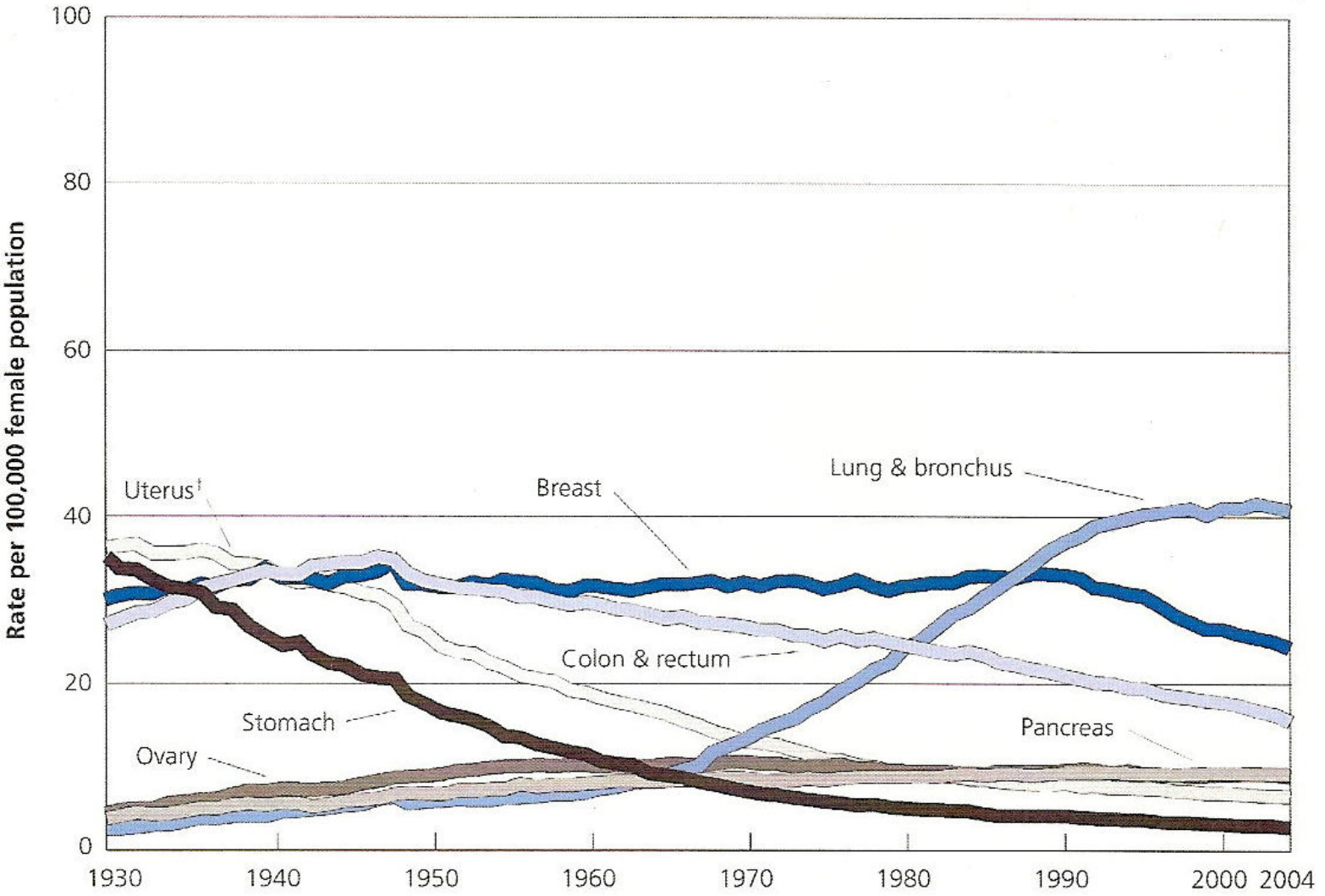
*Per 100,000, age-adjusted to the 2000 US standard population.

Note: Due to changes in ICD coding, numerator information has changed over time. Rates for cancer of the liver, lung and bronchus, and colon and rectum are affected by these coding changes.

Source: US Mortality Data 1960 to 2004, US Mortality Volumes 1930 to 1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2006.

American Cancer Society, Surveillance Research, 2008

Age-Adjusted Cancer Death Rates,* Females by Site, US, 1930-2004



*Per 100,000, age-adjusted to the 2000 US standard population. †Uterus cancer death rates are for uterine cervix and uterine corpus combined.

Note: Due to changes in ICD coding, numerator information has changed over time. Rates for cancer of the lung and bronchus, colon and rectum, and ovary are affected by these coding changes.

Source: US Mortality Data 1960 to 2004, US Mortality Volumes 1930 to 1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2006.

American Cancer Society, Surveillance Research, 2008

Worldwide Lung Cancer

- Estimated **1.5 million** new cases of Lung cancer expected each year
- Accounts for **12%** of total cancer diagnoses

- More than **1.3 million** people expected to die from Lung cancer each year

- Leading cause of cancer death in Men
- Second leading cause of cancer death in Women

Lung Cancer Survival Rates

Table 1. Changes in 5-Year Survival, Mortality, and Incidence for 20 Solid Tumors

Primary Site	5-Year Survival, %		Absolute Increase in 5-Year Survival, %	% Change (1950-1996)	
	1950-1954	1989-1995		Mortality	Incidence
Prostate	43	93	50	10	190
Melanoma	49	88	39	161	453
Testis	57	96	39	–73	106
Bladder	53	82	29	–35	51
Kidney	34	61	27	37	126
Breast	60	86	26	–8	55
Colon	41	62	21	–21	12
Rectum	40	60	20	–67	–27
Ovary	30	50	20	–2	3
Thyroid	80	95	15	–48	142
Larynx	52	66	14	–14	38
Uterus	72	86	14	–67	0
Cervix	59	71	12	–76	–79
Oral cavity	46	56	10	–37	–38
Esophagus	4	13	9	22	–8
Brain	21	30	9	45	68
Lung	6	14	8	259	249
Stomach	12	19	7	–80	–78
Liver	1	6	5	34	140
Pancreas	1	4	3	16	9

Trends in 5-Year Relative Survival Rates* (%) by Race and Year of Diagnosis, US, 1975-2003

Site	White			African American			All Races		
	1975-77	1984-86	1996-2003	1975-77	1984-86	1996-2003	1975-77	1984-86	1996-2003
All sites	51	55	67†	40	41	57†	50	54	66†
Brain	23	28	34†	27	33	37†	24	29	35†
Breast (female)	76	80	90†	62	65	78†	75	79	89†
Colon	52	60	66†	46	50	55†	51	59	65†
Esophagus	6	11	18†	3	8	11†	5	10	16†
Hodgkin lymphoma	74	80	87†	71	75	81†	74	79	86†
Kidney	51	56	66†	50	54	66†	51	56	66†
Larynx	67	68	66	59	53	50	67	66	64
Leukemia	36	43	51†	34	34	40	35	42	50†
Liver#	4	6	10†	2	5	7†	4	6	11†
Lung & bronchus	13	14	16†	12	11	13†	13	13	16†
Melanoma of the skin	82	87	92†	60‡	70§	77	82	87	92†
Myeloma	25	27	34†	31	32	32	26	29	34†
Non-Hodgkin lymphoma	48	54	65†	49	48	56	48	53	64†
Oral cavity	55	57	62†	36	36	41	53	55	60†
Ovary	37	39	45†	43	41	38	37	40	45†
Pancreas	3	3	5†	2	5	5†	2	3	5†
Prostate	70	77	99†	61	66	95†	69	76	99†
Rectum	49	58	66†	45	46	58†	49	57	66†
Stomach	15	18	22†	16	20	24†	16	18	24†
Testis	83	93	96‡	82‡	87‡	88	83	93	96†
Thyroid	93	94	97†	91	90	94	93	94	97†
Urinary bladder	75	79	81†	51	61	65†	74	78	81†
Uterine cervix	71	70	74†	65	58	66	70	68	73†
Uterine corpus	89	85	86†	61	58	61	88	84	84†

*Survival is adjusted for normal life expectancy and based on cases diagnosed in the SEER 9 areas from 1975-1977, 1984-1986, and 1996-2003, and followed through 2004. †The difference in rates between 1975-1977 and 1996-2003 is statistically significant ($p < 0.05$). ‡The standard error of the survival rate is between 5 and 10 percentage points. §The standard error of the survival rate is greater than 10 percentage points. #Includes intrahepatic bile duct.

Source: Ries LAG, Melbert D, Krapcho M, et al (eds.). *SEER Cancer Statistics Review, 1975-2004*, National Cancer Institute, Bethesda, MD, www.seer.cancer.gov/csr/1975_2004/, 2007.

American Cancer Society, Surveillance Research, 2008

Risk Factors

- Smoking
  - Responsible for 87% of Lung Cancer Deaths Annually
  - Latent period of 20-25 years
  - Dose related
    - (9-10 fold risk average smoker, 20 fold risk for heavy smoker)
  - Smoking *reduces the lifespan of average American by* ***14 years***
- Secondhand smoke
  - Non-smoking spouses who live with a smoker have a 20-30% greater risk
- Radon Exposure
- Asbestos Exposure
  - Synergy with Tobacco (*50-90 times the risk* of cancer)
- Other Environmental exposures
  - Arsenic, Chromium, Nickel, Silica, Soot or Tar
  - Benzopyrene, Vinyl Chloride, Diesel exhaust
- Beta carotene supplements – only in smokers

Risk Factors

- Genetic Factors
  - p53 tumor suppressor gene mutation
  - k-ras oncogene activation
- Personal or Family History Lung Cancer

- Air pollution
  - *Worldwide, 5% of deaths from Lung cancer may be due to air pollution*

- Recurring inflammation
  - Scarring from Tuberculosis or recurrent pneumonias can increase risk
- Prior Radiation Treatment
  - Mantle cell lymphoma
  - Breast cancer - Non smoking women with radiation to breast after lumpectomy do NOT have increased risk of lung cancer

Risk Factors

- Race / Ethnicity
  - African Americans have similar rate of smoking as Whites (20% vs 22% in 2004); yet
    - Black men are 50% more likely to develop lung cancer
    - 30% more likely to die from lung cancer than White men
  - Hispanics smoke less (15% in 2004) than Whites or African Americans
    - 50% lower lung cancer rate than Whites
    - 60% lower lung cancer rate than African Americans
  - High school students smoking trend is alarming: data from 2004 →
    - Hispanics 26.2%
    - African Americans 17.1%
    - Whites 31.5%

Sign and Symptoms

- Cough (that does not resolve) 29-87%
- Hemoptysis 9-57%
- Pleuritic chest pain 6-60%
- Shortness of Breath / Dyspnea 3-58%
- Wheezing (new onset) / Stridor 2-14%
- Hoarseness 1-18%
- Pleural Effusion 7%
- Dysphagia 2-6%
- Superior vena cava syndrome 4-11%
- Pancoast's Syndrome / Horner's Syndrome 3-5%
- Phrenic Nerve paralysis 1%
- Neurologic Metastasis 10%
- Bone Metastasis 22%
- Liver Metastasis 5%
- Adrenal Metastasis 2-4%
- Paraneoplastic Syndromes 10-20%
  - SIADH 1-27% Hypercalcemia 1-12% Cushing's 2-6%
- ASYMPTOMATIC
  - All patients with Lung cancer 5-20%
  - Patients detected in screening programs 60%

WHO Classification (1999) for NSCLC (80% of Lung CA)

- **Squamous Cell Carcinoma (30%)**
  - Most commonly in Men
  - Tends to spread Locally and usually central lesions
  - Related to Smoking
  - More readily detected in Sputum
- **Adenocarcinoma (30-50%)**
  - Most commonly in Women and Non-smokers, but Smoking is risk factor
  - Usually peripheral lesions
  - Metastasize early
  - Bronchoalveolar Carcinoma (BAC) is a subtype
- **Large Cell Carcinoma (10-25%)**
  - Undifferentiated, primitive cells
  - Metastasize early
  - Usually peripheral lesions
- **Adenosquamous Carcinoma**
- **Carcinomas with Pleomorphic or Sarcomatous elements (0.5%)**
- **Carcinoid tumor (3-5%)**
- **Carcinomas of Salivary-gland type**
- **Unclassified Carcinoma**

TNM Definitions

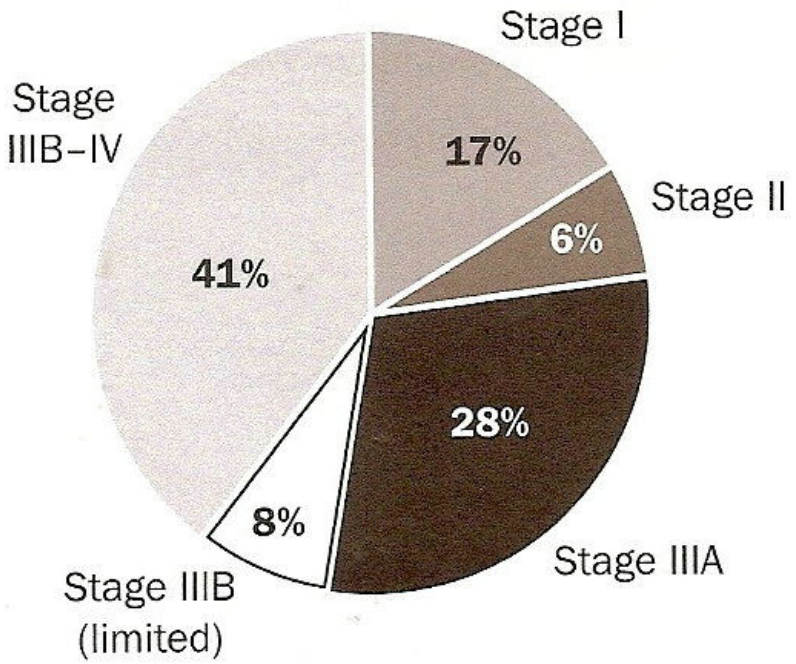
- T Stage
  - Size of the Primary Tumor
  - Adjacent structures invaded into by Tumor
- N Stage
  - Nodal disease involvement
- M Stage
  - Metastatic disease involvement

Stage	TNM Classifcation	5 Year Survival
IA	T1N0M0	67
IB	T2N0M0	57
IIA	T1N1M0	55
IIB	T2N1M0 or T3N0M0	39
IIIA	T1-3N2M0 or T3N1M0	23
IIIB	$T4N_{any}M0$ or $T_{any}N3M0$	5
IV	$T_{any}N_{any}M1$	1

Mountain, *Chest* 1997

Staging

NSCLC Incidence by Stage
US Population, 2006



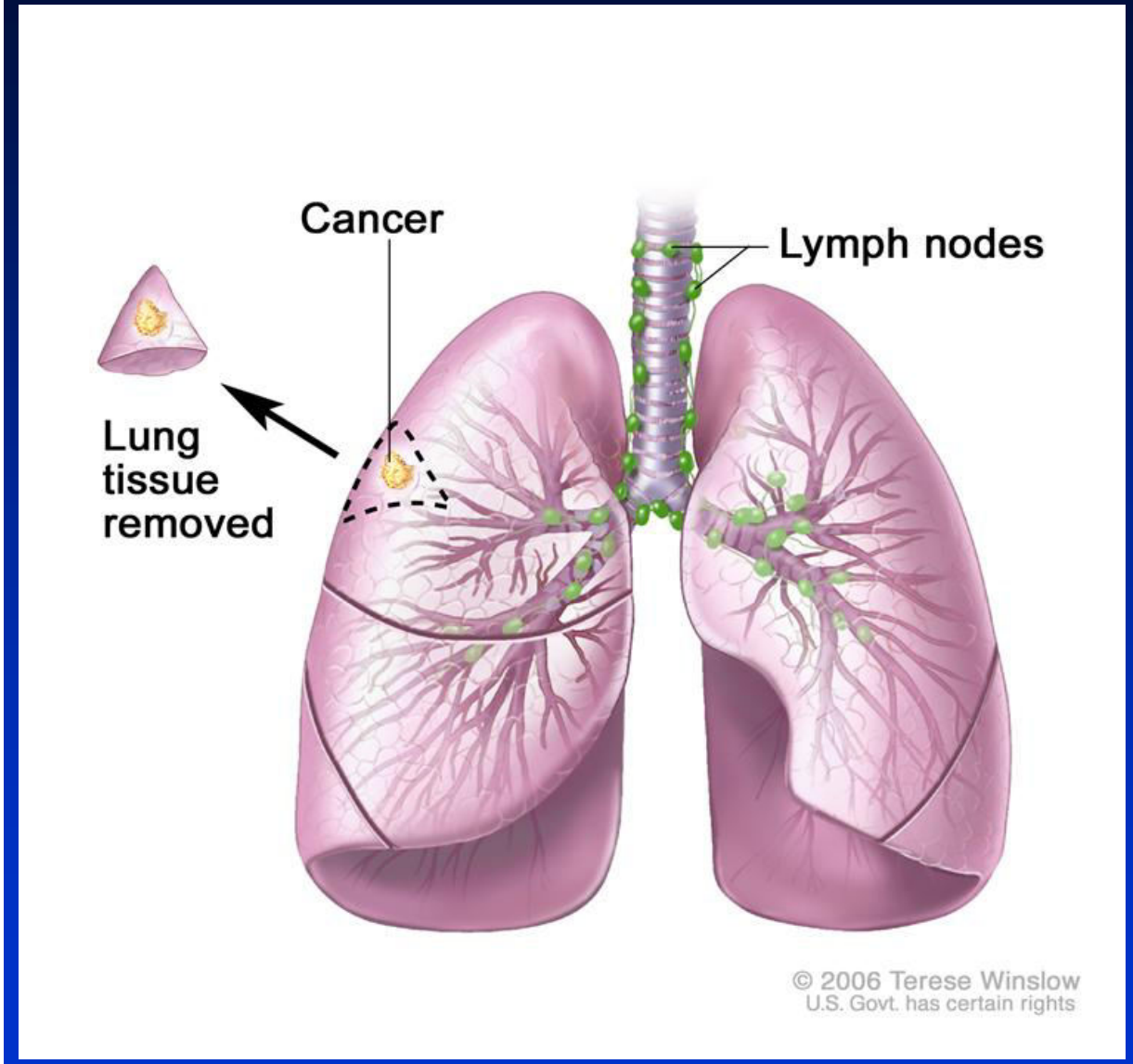
Disease and Stage	Annual Incidence	1-Year Survival	5-Year Survival
NSCLC	**140,000**	—	**17%**
I	24,000	90%	70%
II	9,000	80%	40%
IIIA	42,000	70%	20%
IIIB (limited)	11,000	50%	4%
IIIB–IV	57,000	35%	3%

Treatment of Lung Cancer According to Stage

Stage	Primary treatment	Adjuvant therapy	Five-year survival rate (%)
Non-small cell carcinoma			
I	Resection	Chemotherapy	60 to 70
II	Resection	Chemotherapy with or without radiotherapy	40 to 50
IIIA (resectable)	Resection with or without preoperative chemotherapy	Chemotherapy with or without radiotherapy	15 to 30
IIIA (unresectable) or IIIB (involvement of contralateral or supraclavicular lymph nodes)	Chemotherapy with concurrent or subsequent radiotherapy	None	10 to 20
IIIB (pleural effusion) or IV	Chemotherapy or resection of primary brain metastasis and primary T1 tumor	None	10 to 15 (two-year survival)
Small cell carcinoma			
Limited disease	Chemotherapy with concurrent radiotherapy	None	15 to 25
Extensive disease	Chemotherapy	None	< 5

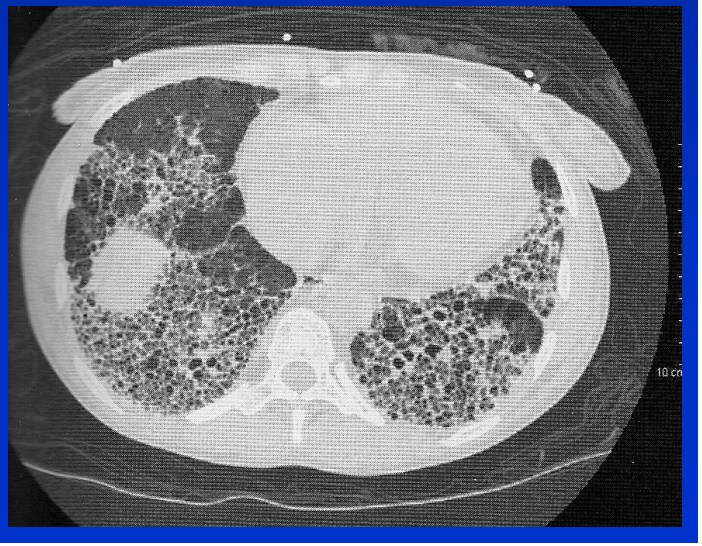
Adapted with permission from Spira A, Ettinger DS. Multidisciplinary management of lung cancer. N Engl J Med 2004;350:388.

Wedge Resection

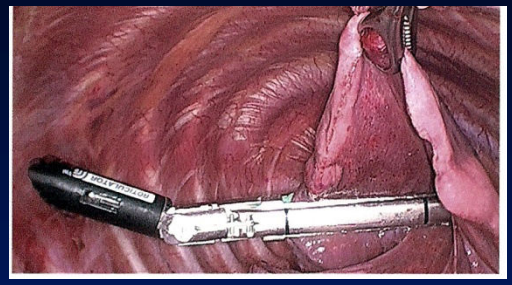
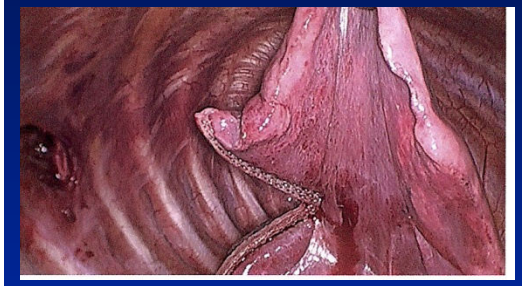
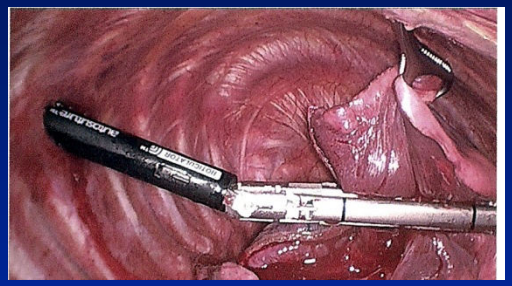
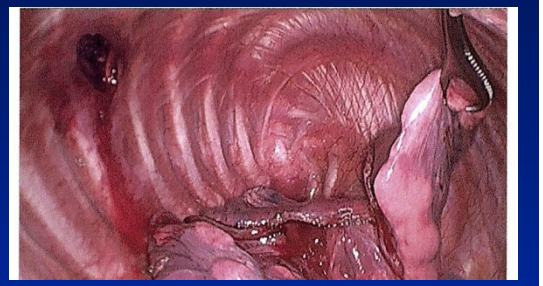
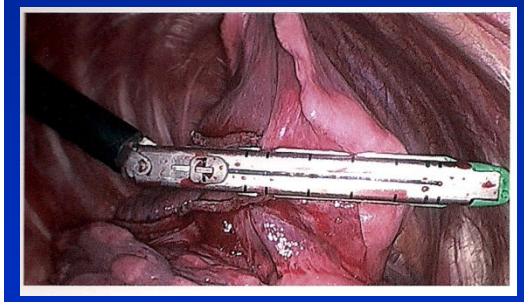
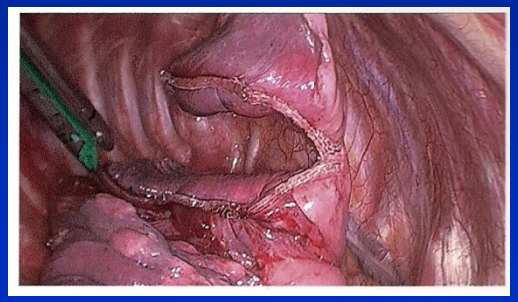
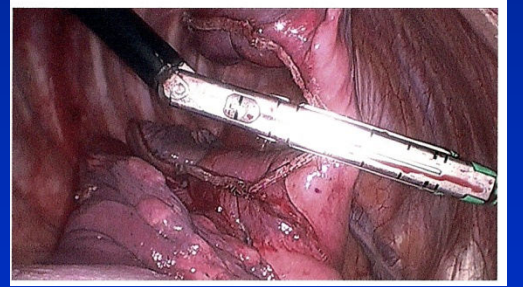


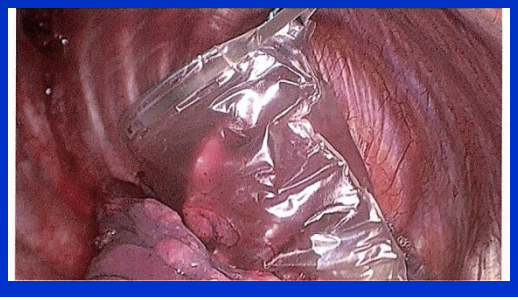
Wedge resection is a nonanatomic resection of a small portion of the lung. This is usually done to make a diagnosis with respect to a lung nodule or mass, and can be done to treat lung cancer in patients whose lung function does not permit a more extensive cancer operation such as lobectomy. It is also used on patients to make a diagnosis to aid in the treatment of an underlying pulmonary condition.

Today, we perform wedge resections **minimally invasively thru a VATS approach**. The advantages include smaller incision, no rib spreading or cutting, less pain, shorter hospital stay, and earlier return to normal activity and work. Also, the minimally invasive technique allows us to offer surgery to higher risk patients who would otherwise not be candidates for traditional surgery.

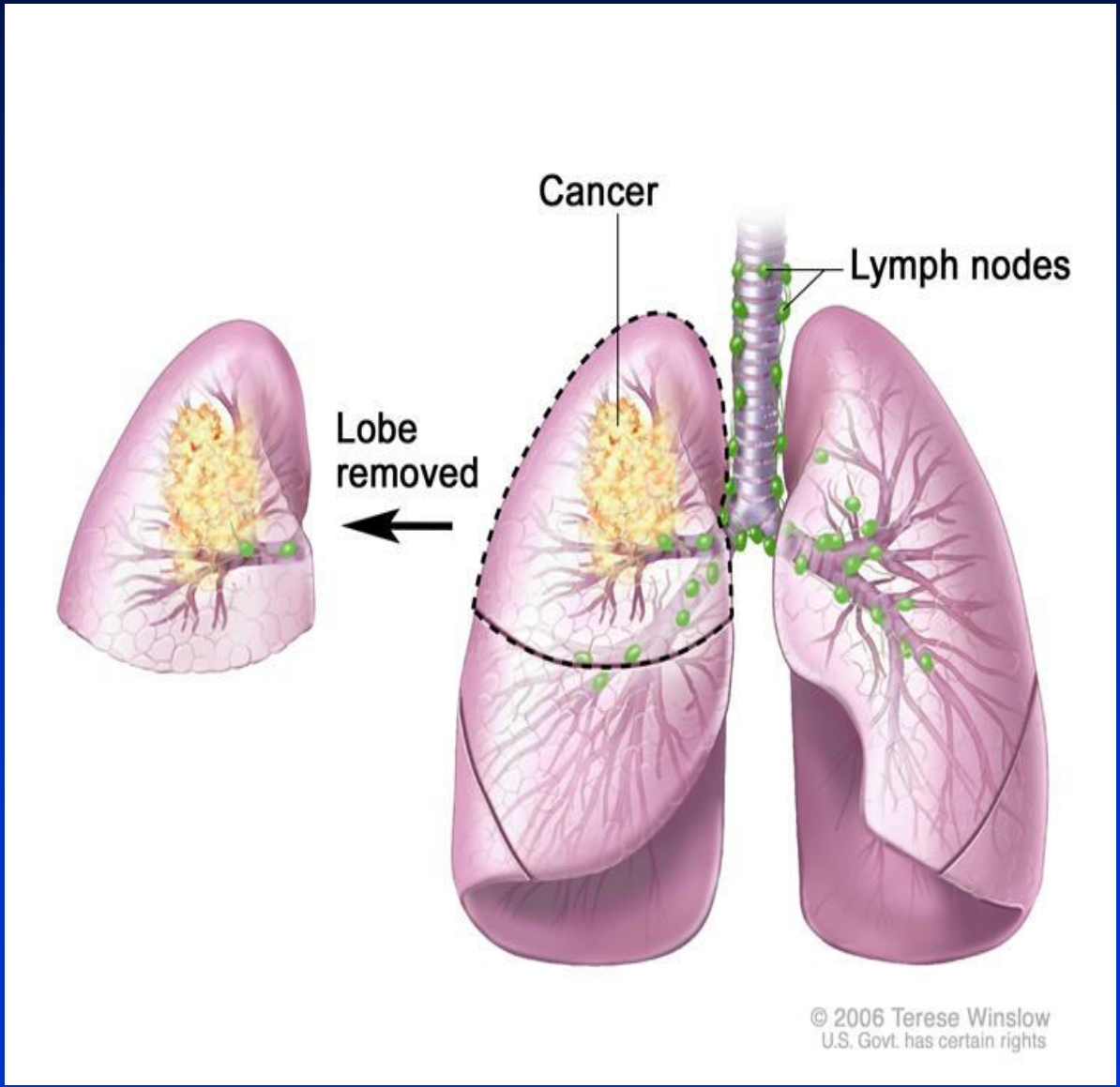







Lobectomy



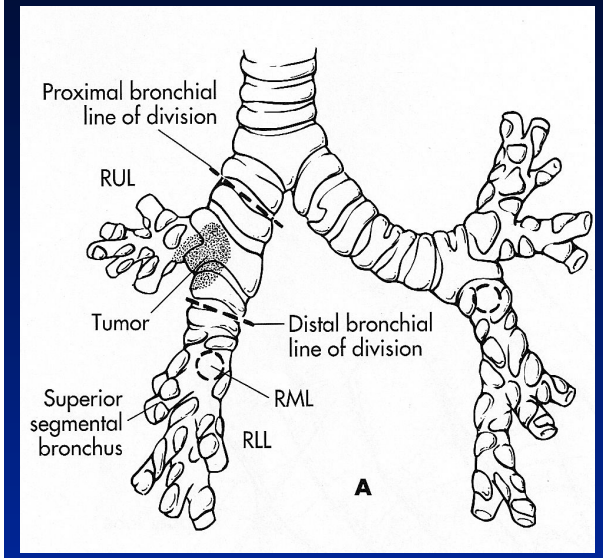
Lobectomy is the removal of a lobe of the lung, usually to treat lung cancer. Traditionally, a thoracotomy was used to accomplish this, but the incision was large, painful, led to many postsurgical complications.

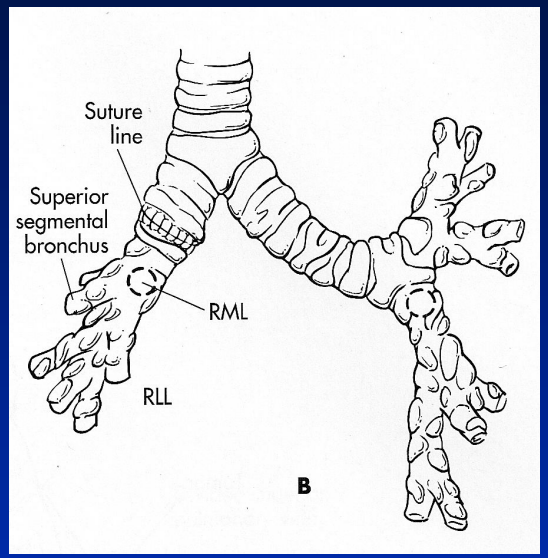
Today, we can perform a lobectomy minimally invasively thru a VATS approach.

The advantages include smaller incision, no rib spreading or cutting, less pain, less pneumonia (3% vs 19% in open lobectomy), less atrial fibrillation (3% vs 20% in open lobectomy), shorter hospital stay (4 days vs 9 days in open lobectomy), and earlier return to normal activity and work.

Also, the minimally invasive technique allows us to offer surgery to higher risk patients who would otherwise not be candidates for traditional surgery.

Sleeve Lobectomy

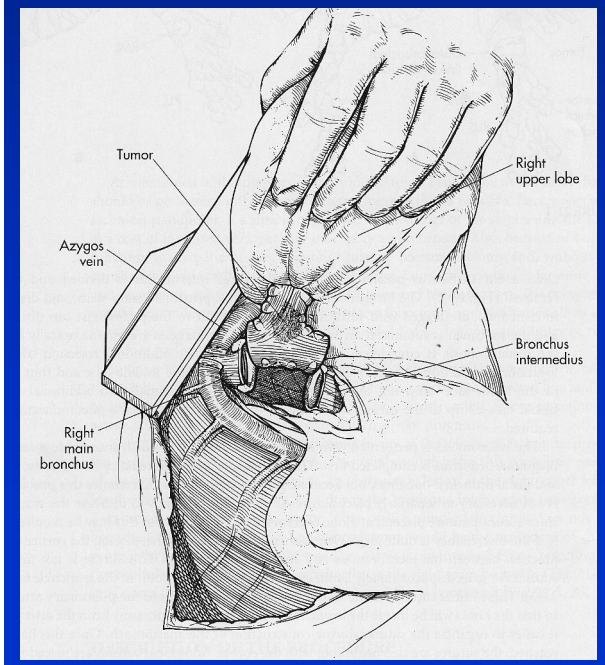


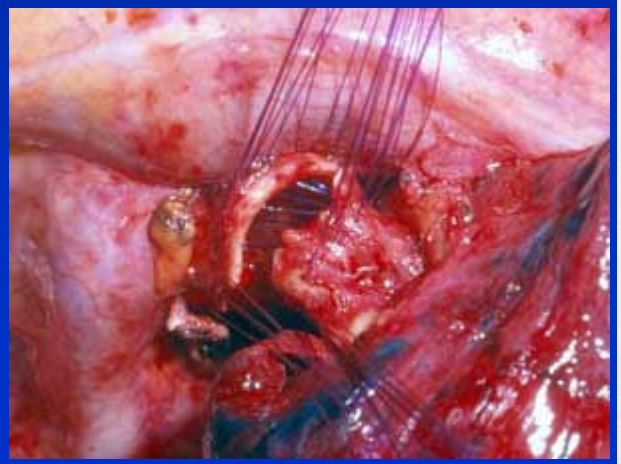


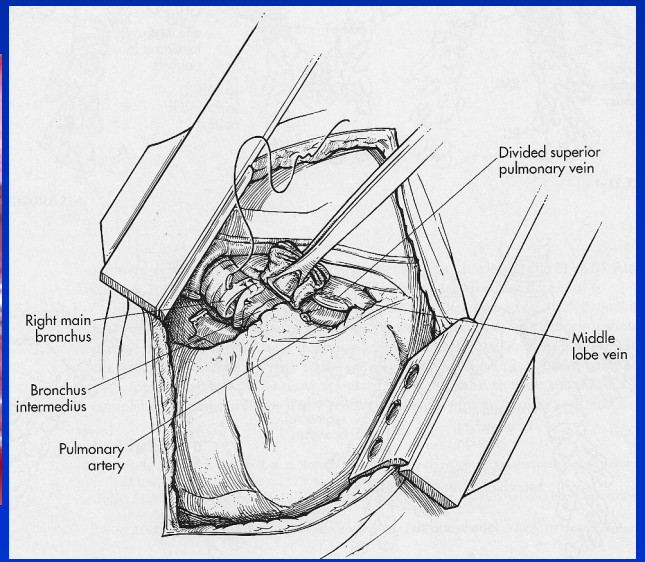
Sleeve lobectomy is an operation used for tumors or diseases that are not amenable to simple lobectomy. This is usually because the tumor or disease involves the origin of a lobar bronchus.

The involved lobe is removed and the ends of the bronchus are rejoined and any remaining lobes are reattached to the bronchus. The sleeve resection therefore, spares uninvolved lung and maintains more respiratory function. The main goal of a sleeve resection is to avoid a pneumonectomy which is the removal of the entire lung.

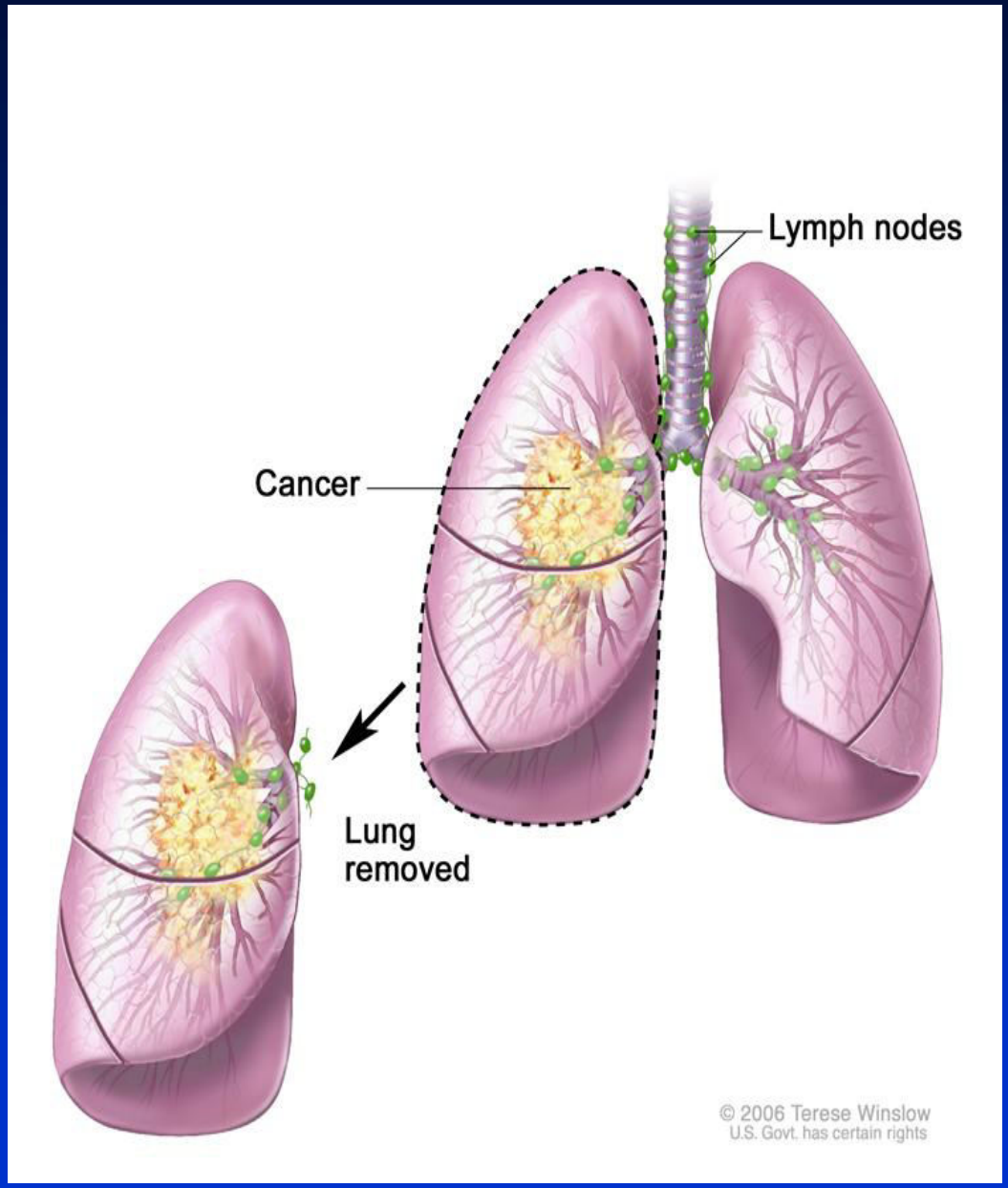
Sleeve resections based upon their complexity require a traditional thoracotomy approach.







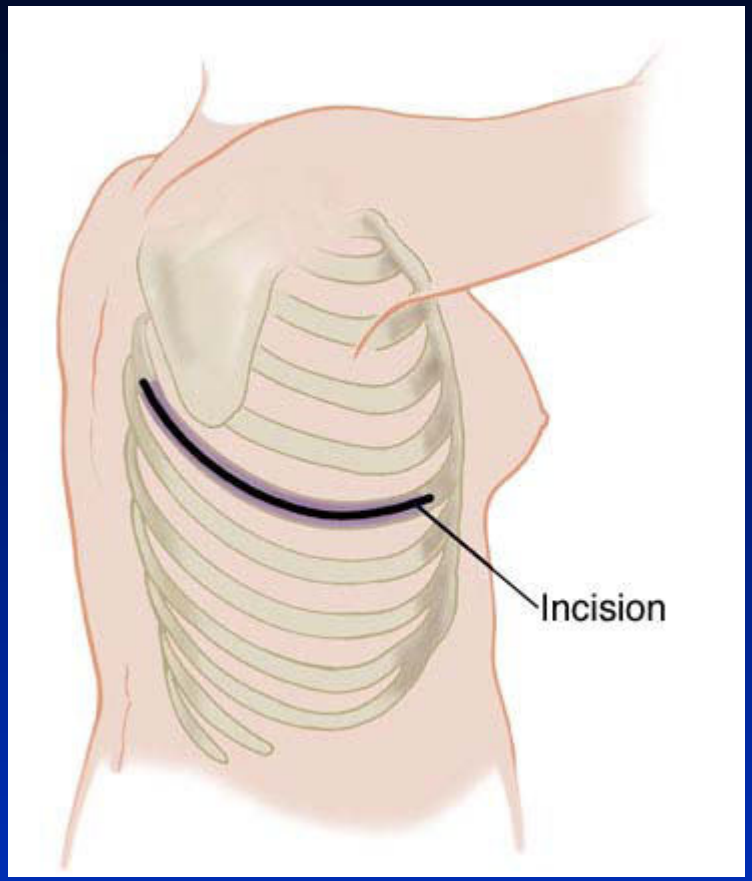
Pneumonectomy

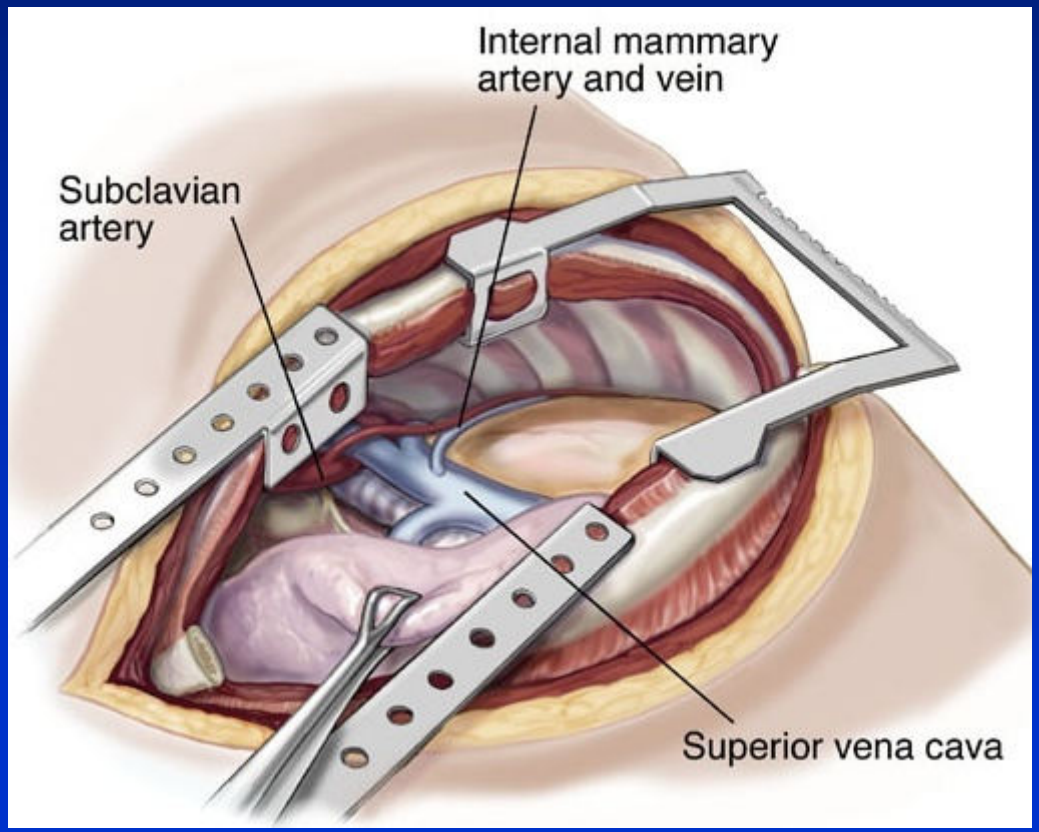


Pneumonectomy is the removal of an entire lung, usually done for lung cancer. Patients can live on only one lung if needed, provided their pulmonary function is adequate.

Pneumonectomy is however an aggressive surgical approach and does have significant risks when compared to lobectomy.

Based upon its complexity, a pneumonectomy requires a traditional thoracotomy approach.


Incision


Internal mammary
artery and vein
Subclavian
artery
Superior vena cava

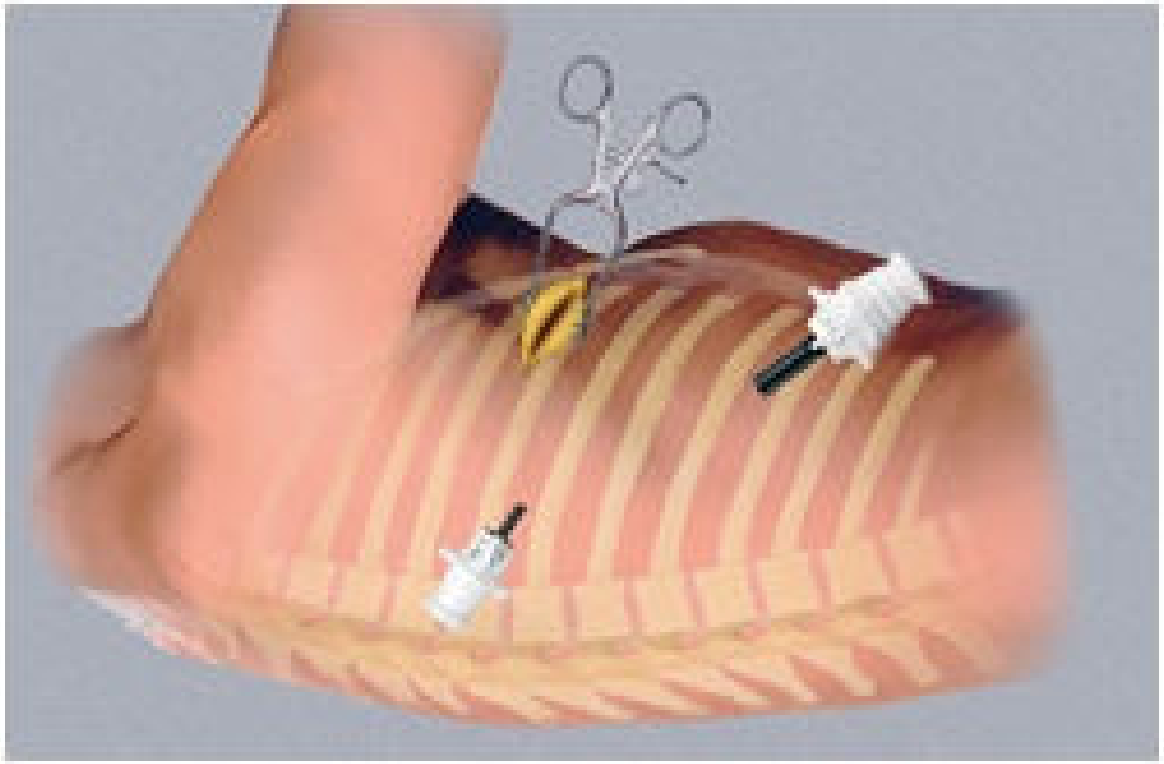
VATS Lobectomy

Video Assisted Thorascopic Surgery

VATS Lobectomy

- Standardize the definition of a VATS lobectomy to encompass a true anatomic lobectomy with individual ligation of lobar vessels and bronchus as well as hilar lymph node dissection or sampling using the video screen for guidance, two or three ports, and no retractor use or rib spreading.

CALBG 39802, 2007



Example of VATS Incisions

Video-Assisted Thoracic Surgery Lobectomy: Experience With 1,100 Cases

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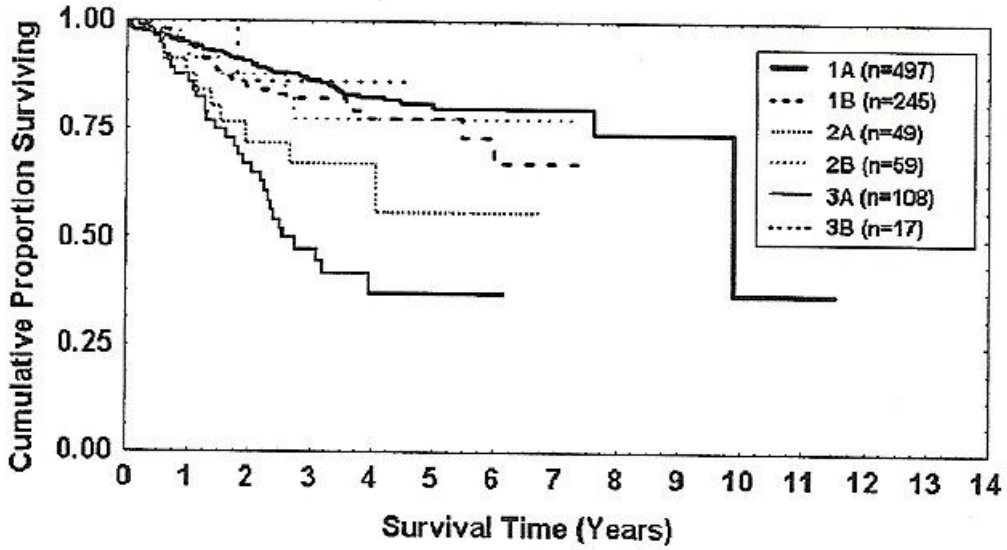
Table 1. Anatomic Pulmonary Resections Done With Video-Assisted Thoracic Surgery

Type of Resection	Number
Right upper lobectomy	403
Right middle lobectomy	92
Right lower lobectomy	158
Pneumonectomy	14
Segmentectomy	19
Sleeve lobectomy	3
Bilobectomy	18
Bilateral lobectomy	1
Left upper lobectomy	279
Left lower lobectomy	113



At Risk

1A	403	283	199.5	136	84.5	47	26.5	11	3	2	1	.5
1B	193.5	154	124	96.5	70.5	53	32.5	20	13.5	6.5	2	.5
2A	37	26.5	21.5	17	13.5	9.5	6.5	4	35	2	1	.5
2B	44	32.5	25	18.5	14	9	7	6	5	3	1	.5
3A	83.5	60	46	36	27.5	17.5	11.5	8.5	6	3	1	.5
3B	12	8.5	8	7.5	7	6	5	4	4	3	1.5	.5

Results

- Mortality Rate = 0.8%
- Complication Rate = 15.3%
- Arrhythmias = 2.9%
- Prolonged Air Leak = 5.1%

- Conversion Rate = 2.5%
- Mean Age of Patients = 71.2 years
- Mean LOS = 4.78 days
- 20% discharged POD 1 or 2

ACOSOG Z0030 Trial :

- Open thoracotomy in patients older than 70 years, morbidity of 40-50%
- Atrial Arrhythmias = 15%
- Prolonged Air Leak = 8%
- Mortality Rate = 2.3% (Older than 70 years)

Thomas et al:

- Open thoracotomy in patients older than 70 years, mortality rate 12.8%

Oncologic Benefit of VATS?

Petersen et al:

- **VATS lobectomy has greater likelihood of planned delivery of adjuvant therapy after surgery**

- **61% VATS lobectomy received 75% or more planned adjuvant therapy without delay or dose reduction**

versus

- **40% open lobectomy received 75% or more planned adjuvant therapy**

Quality of Life:
Demmy et al, *Ann Thor Surg* 2008

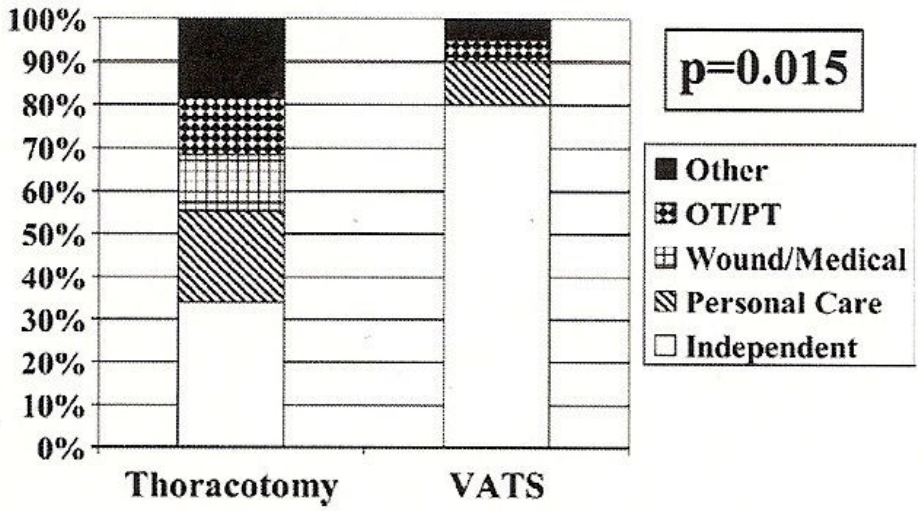


Fig 1. Discharge independence after thoracoscopic lobectomy. The bar graphs demonstrate a much lower need for home health services in the video-assisted thoracic surgery (VATS) group. The types of services needed for each procedure type are displayed as well. (OT = occupational therapy; other = other miscellaneous care needs; PT = physical therapy.) Adapted from Demmy TL, et al. Discharge independence with minimally invasive lobectomy. Am J Surg 2004;188:698–702.

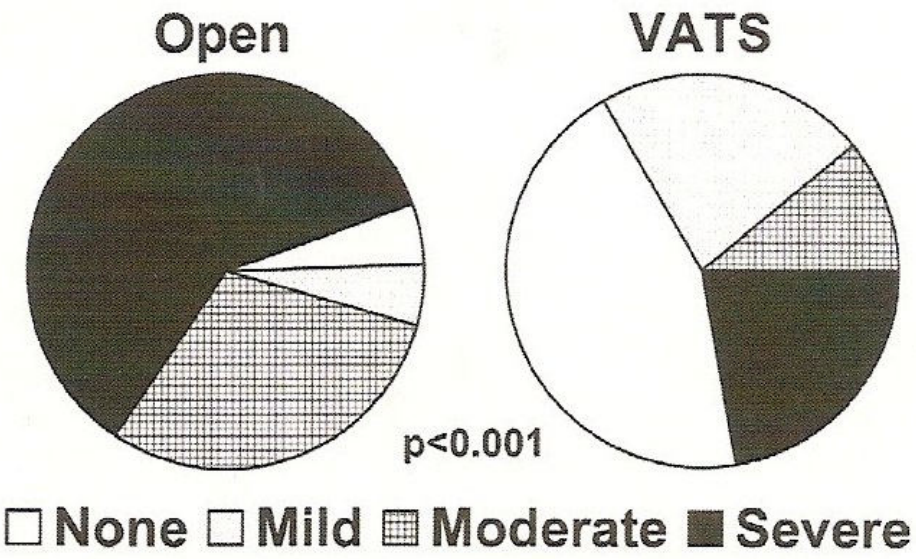


Fig 2. Pain control at 3 weeks after video assisted thoracic surgery (VATS) lobectomy. The pie charts show that VATS patients have significantly ($p < 0.01$) less pain as measured by the most potent analgesic still required: severe—schedule 2 narcotic; moderate—schedule 3 or lower; mild–nonsteroidal anti-inflammatory drugs or acetaminophen. These data represent an updated series of high-risk reported previously [49, 61].

Benefit of VATS Lobectomy in the Elderly

Koizumi et al:

- 32 octogenarian or nonagenarian patients
- 5 year survival rate of 56% with VATS lobectomy with early stage cancer

Versus

- 5 year survival rate of 0% with open lobectomy with early stage cancer

Use of Video-Assisted Thoracic Surgery for Lobectomy in the Elderly Results in Fewer Complications

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Table 2. Perioperative Data

Characteristics	THOR (n = 82)	VATS (n = 82)	*p* Value[a]
Histology			
Adenocarcinoma	24 (29)	24 (29)	0.14
Adeno w/BAC	27 (33)	32 (39)	
Squamous	24 (29)	13 (16)	
Other	7 (10)	13 (16)	
Tumor diameter (range), cm	2.0 (0.3–8.0)	1.8 (0.1–7.5)	0.11
Pathologic stage			
IA	49 (60)	56 (68)	0.13
IB	15 (18)	19 (23)	
II	8 (10)	3 (4)	
III–IV	10 (12)	4 (5)	
Length of stay (range), days	6 (2–27)	5 (2–20)	<0.001
Complications, n (%)	37 (45)	23 (28)	0.04
Death, n (%)	3 (3.6)	0 (0)	0.10

Average age = 76 years

Table 4. Complication Profile

Type, n (%)	THOR (n = 82)	VATS (n = 82)	*p* Value[a]
None	45 (55)	59 (72)	0.04
Pulmonary	27 (33)	12 (15)	0.01
Cardiac (atrial fibrillation)	19 (23)	14 (17)	0.44
Genitourinary	5 (6)	2 (2)	
Gastrointestinal	4 (5)	0 (0)	
Infectious	4 (5)	1 (1)	
Neurologic	1 (1)	3 (4)	
Other	2 (2)	0 (0)	

VATS Lobectomy Summary

- Enhanced visualization
- Decreased trauma to the tissue
- Decreased postoperative pain
- Decreased postoperative respiratory and other complications
- Decreased Hospital Stay
- Shortened Recovery time, allowing return to work and daily activities sooner
- Ability to offer surgery to higher risk patients who would not be candidates otherwise

Postoperative Care - VATS

General Principles

- Minimize routine laboratory tests.
  - Sometimes postoperatively, always AM POD#1, then as needed
- Daily CXR until chest tube removed.
- Early ambulation – start in halls POD #1.
- Incentive Spirometer use encouraged.
- Nebulizer treatments as needed.
- Laxative for no bowel movement by POD#3 or prior to discharge.

Pain Management

- Local rib blocks in the operating room.
- Toradol if not contraindicated.
- PCA pump for VATS.
- Epidural for VATS lobectomy.
- On-Q pumps for VATS in selected patients.

- Once chest tube is removed, DC PCA or Epidural, begin oral medications (Norco, Vicodin, Percocet) and plan for discharge soon after.

Chest Tube Management

- Chest tube on -20cm H2O suction postoperatively.
- If no air leak in AM of POD#1, then place to waterseal.
- If no change in CXR in AM of POD#2, and output less than 200cc / 24 hours, then remove chest tube.
- I place U-stitch at operation and tie when removing chest tube.
- I routinely use Eviseal to reduce postoperative air leaks.
- If air leak, leave on suction until resolves.
- Persistent air leaks: redo operation, clamp trials, or Heimlich valve.

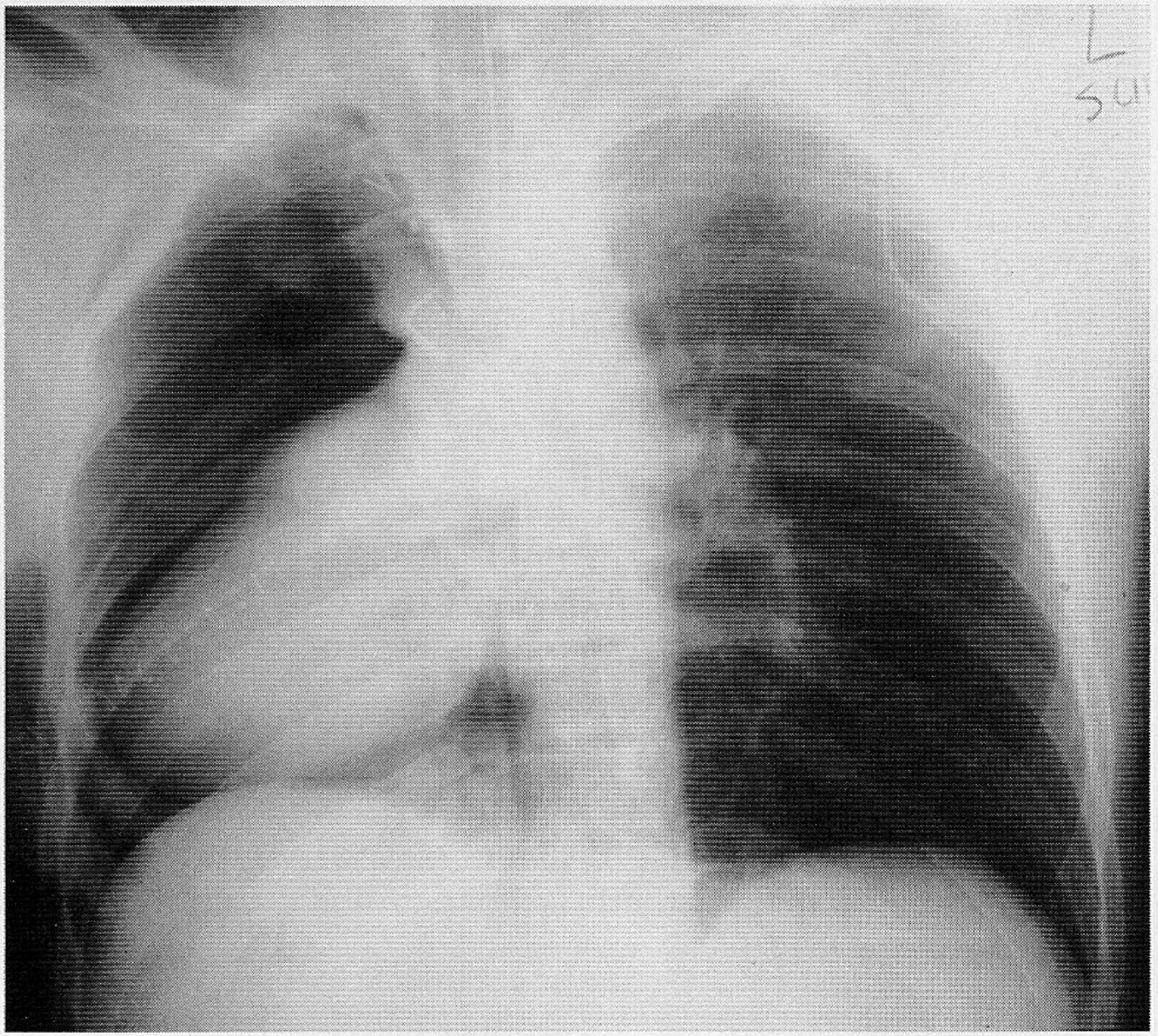
Discharge Instructions

- Ambulate daily – preferably outside the home.
- OK to Shower.
- Shoulder Range of Motion Exercises encouraged:
  - Climb the Wall
  - Shrug shoulders
- Suture Removal of Chest tube stitch in office 10-14 days after surgery.
- See Attached Handout.

Complications

Case 1

Case: Patient is 51 year old male presents with a large right lung squamous cell carcinoma. His pulmonary function tests are excellent and he undergoes a right pneumonectomy. Postoperatively, he goes directly to the ICU where after turning on his right side, he abruptly drops his blood pressure to 50. A portable CXR is done immediately. What do you do? Diagnosis?



Cardiac Volvulus

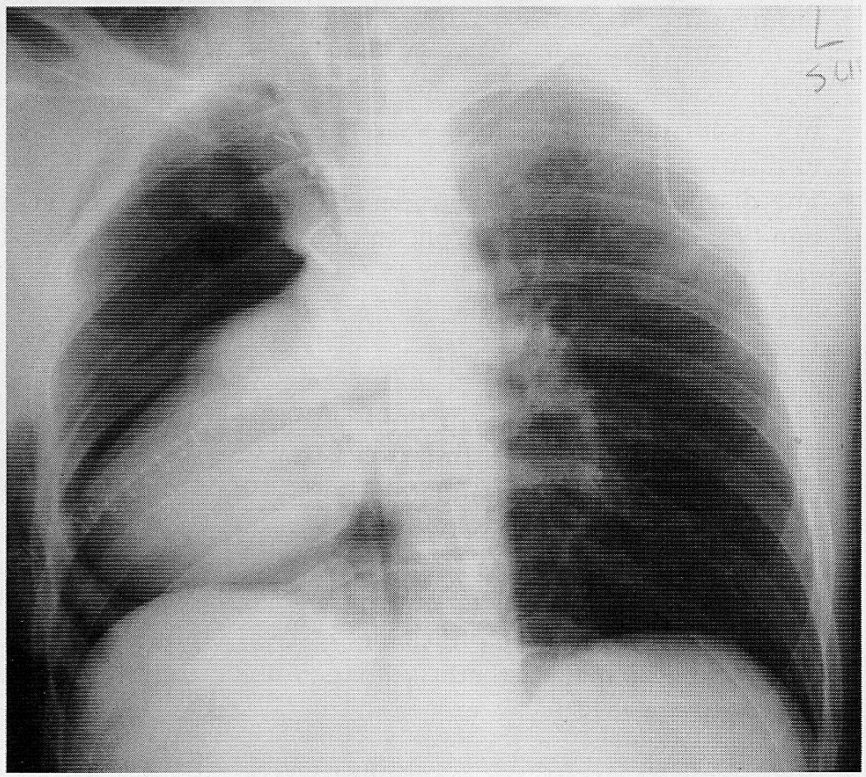
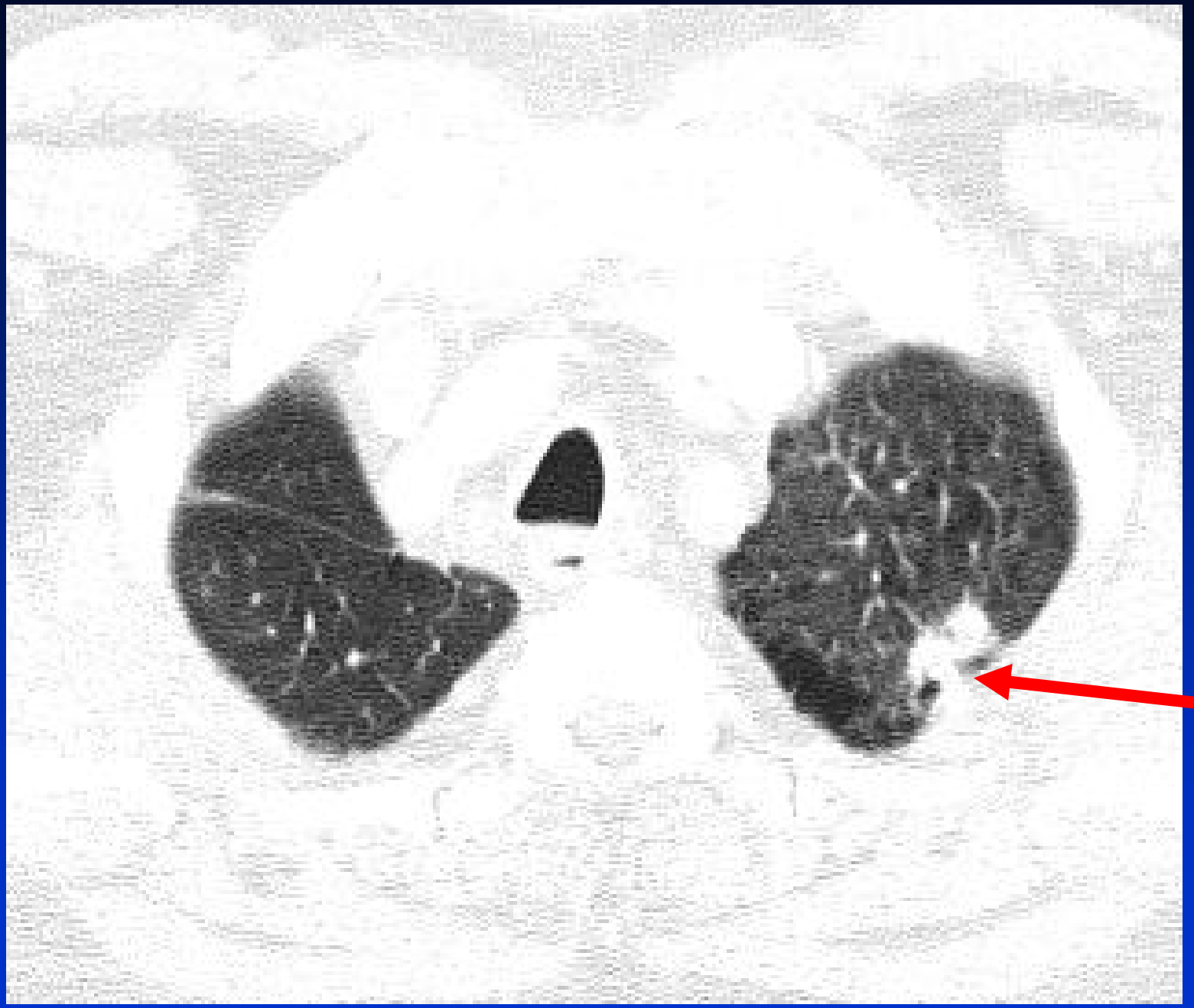


Figure 1-46: Cardiac volvulus following right pneumonectomy. Left central line is kinked at the superior vena cava and the cardiac apex is in the right hemithorax. The volvulus was emergently repaired and the patient recovered completely.

Case 2

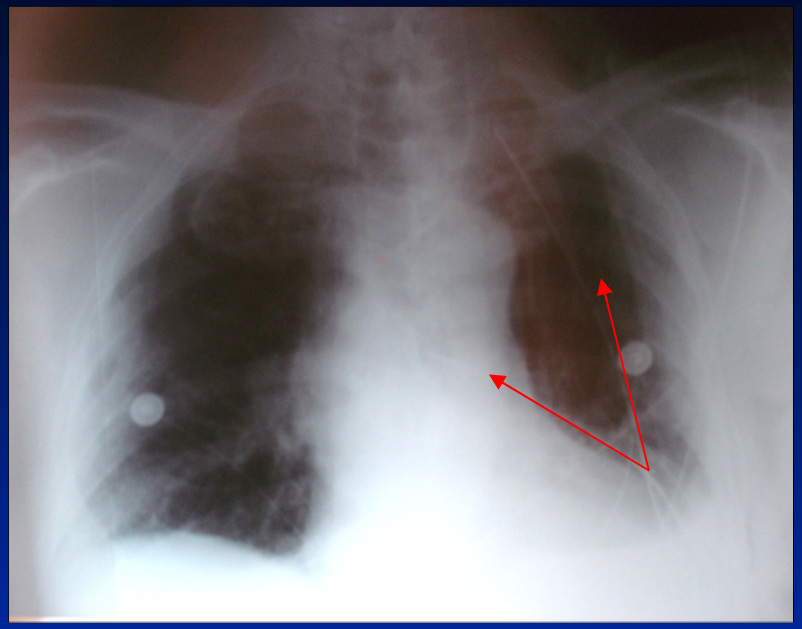
HPI: Patient is 61 year old male with a left upper lobe nodule that increased in size from 1.2 cm to 2.1 cm over the most recent six months, and PET scan showed increased metabolic activity.



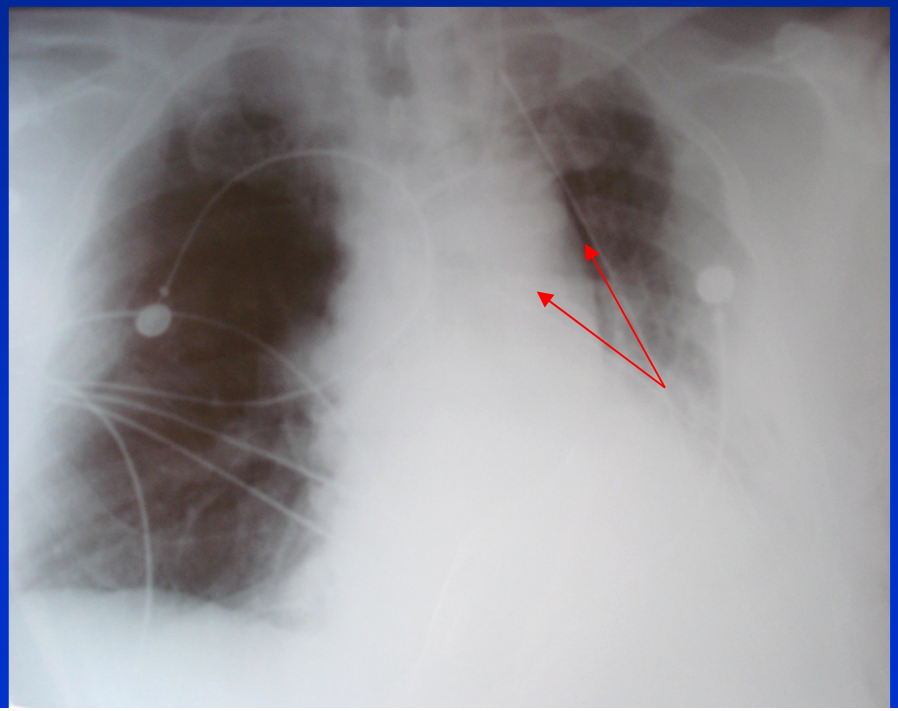
Operating Room

- Thoracic Epidural
- Left Posterolateral Thoracotomy
- Divided Inferior Pulmonary Ligament
- Wedge resection of Left upper lobe lesion
- Frozen section revealed Adenocarcinoma
- Completion Left Upper Lobectomy
- Tested inflation of LLL prior to dividing LUL bronchus
- Tested Bronchial stump for air leak
- Placed 2 chest tubes
- Closed in standard fashion

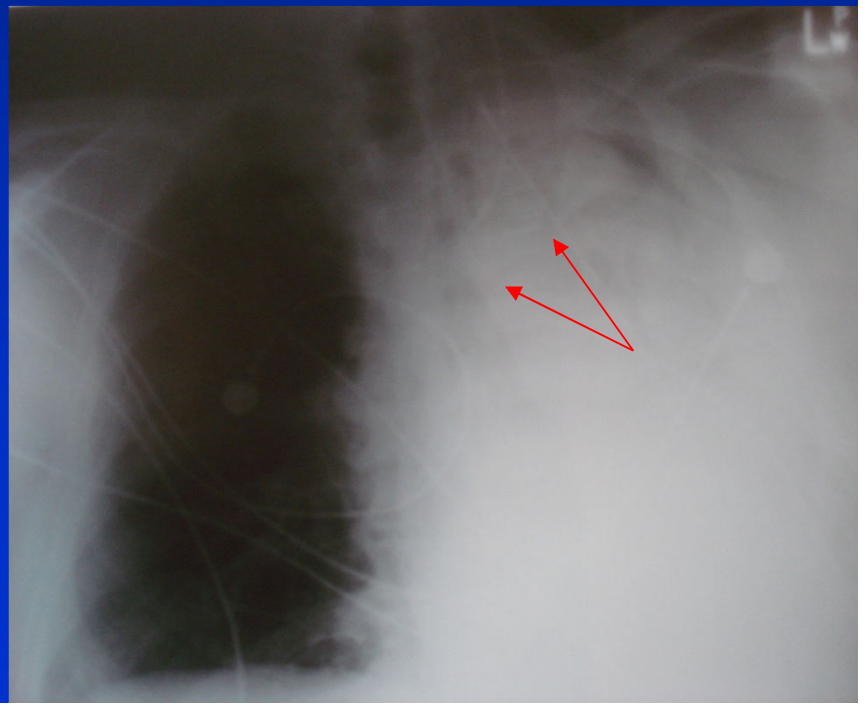
Immediately Postop



POD #1



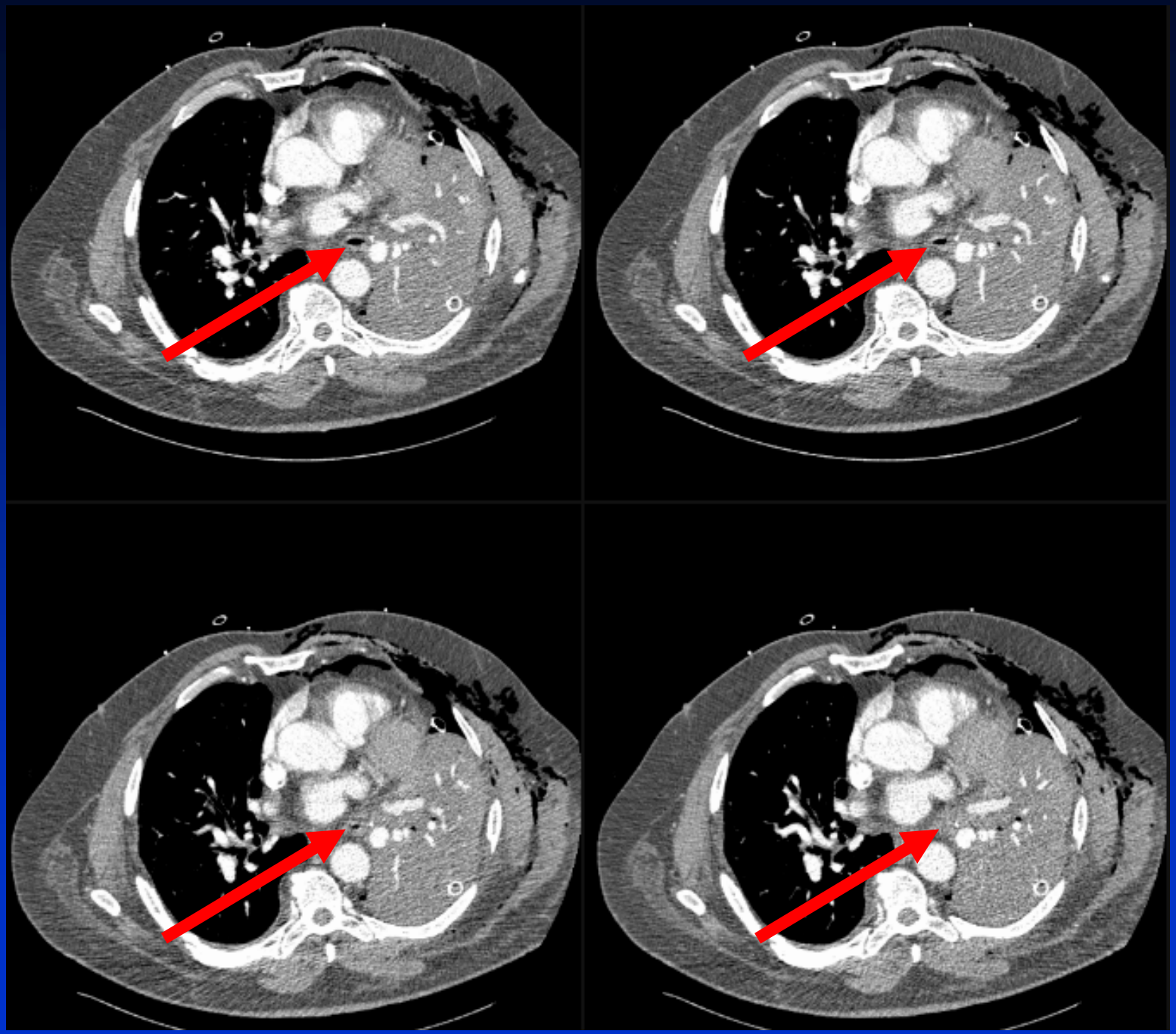
POD #2

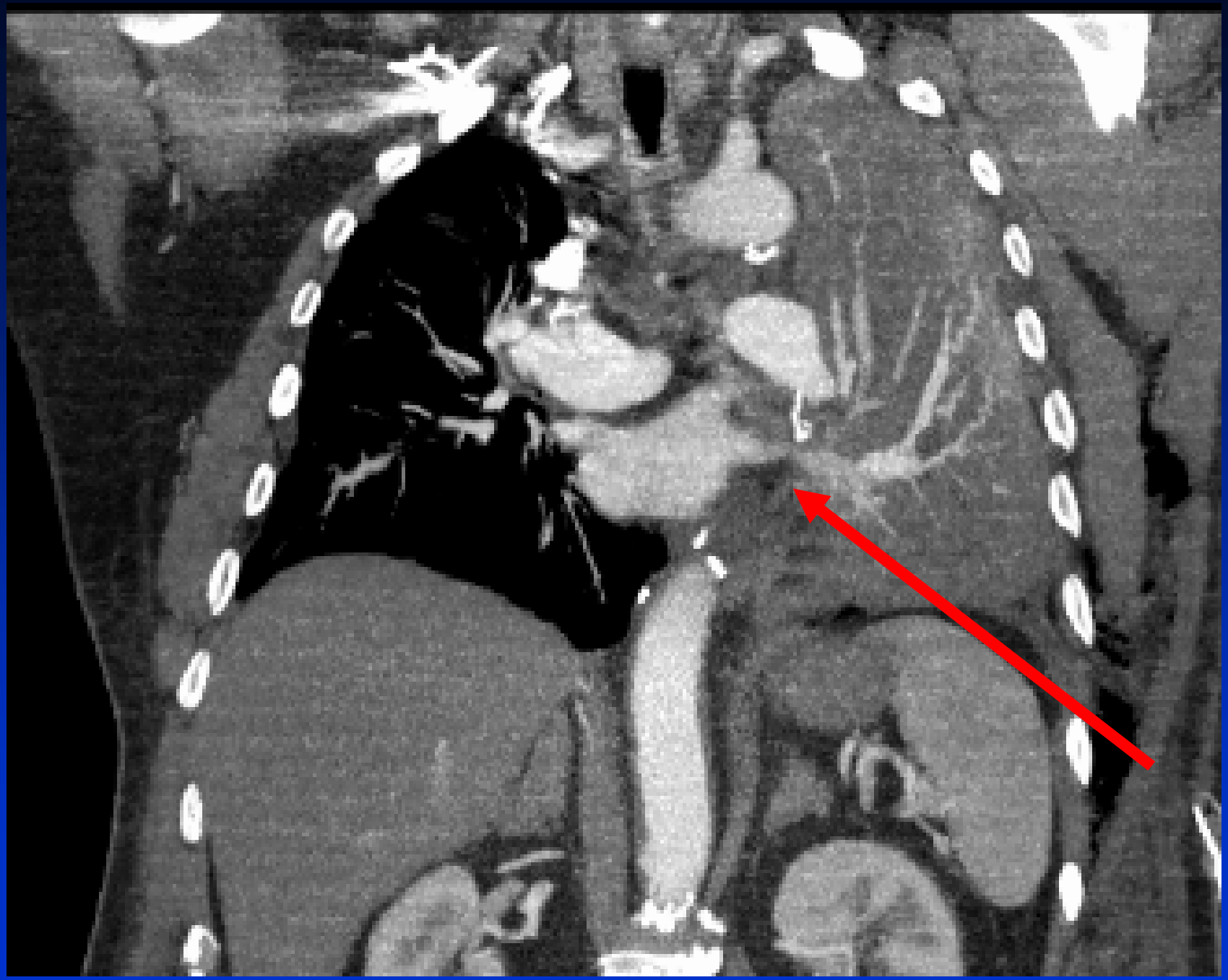


Bronchoscopy

Awake Bedside Bronchoscopy Performed:

- Near complete occlusion of left lower lobe bronchus
- Tremendous difficulty passing bronchoscope into the left lower lobe
- Collapse of lower lobe after removal of scope
- Edema of the airway
- Substantial Bronchorrhea





Diagnosis ?

Lobar Torsion

Incidence

- Occurs rarely with an incidence of approximately 0.2%
  - Yamane et al 2005:
    1002 resections: 2 torsions → 0.2%
    (50% mortality)
  - Cable et al 2001:
    7887 pulmonary resections: 7 torsion cases → 0.089%
  - Larsson et al 1988:
    2000 cases: 4 torsion cases → 0.2%
    (50% mortality)
  - Keagy et al 1985:
    369 patients: 1 torsion → 0.27%

  - Wagner and Nesbitt:
    - 70% after RUL
    - 15% after LUL

Clinical Presentation

- Believed to occur because of:
  - Manipulation at the time of surgery
  - Presence of a complete fissure between the middle lobe and either the upper or lower lobe
  - Right Middle Lobe most frequently involved (complete oblique fissure and narrow middle lobe hilum)

- Torsion results in vascular and bronchial obstruction
- Leads to Ischemic Lung Injury
- Progresses to infarction and finally fatal gangrene if not diagnosed promptly

- Present with:
  - High fevers
  - Hemoptysis
  - Bronchorrhea

- ABG deceptively normal

Diagnosis

- **CXR**
  - Opacification of affected Lung parenchyma
  - Prominent reticular markings
  - Pleural effusion
  - Abnormal location bronchovascular markings

- **Bronchoscopy**
  - No endobronchial lesions
  - Collapsed Bronchus (fishmouth appearance) through which scope can pass
  - Removal of scope leads to prompt re-closure of bronchus
  - Mucosal erythema and edema

- **Chest CT Scan**
  - Can demonstrate bronchial or vascular cutoff

Diagnostic Signs of Torsion

- Opacification of affected lung without hypoxia.
- Narrowing or occlusion of bronchus on bronchoscopy with associated bronchorrhea.
- Voluminous chest tube output.
- Subtle change in chest tube position on chest xray.

Treatment

- **Immediate Operation is Mandatory**
  - Repeat Thoracotomy required
  - Untwist the Lobe
  - Assess Viability
  - Double Lumen tube to prevent retained secretions from affecting the good lung after detorsion.
  - If ischemic injury advanced, need to resect affected parenchyema
  - Right Middle lobe torsion can be prevented by suturing or stapling middle lobe to adjacent lung
  - Some studies suggest that during upper lobectomies, possibly NOT taking down the inferior pulmonary ligament can prevent lower lobe torsion

Early Complications after Pulmonary Resection

- **Hemorrhagic**
  - Postoperative (bronchial artery, chest wall vessel)
  - Sudden Massive (pulmonary artery stump, pulmonary vein)
  - Bronchovascular Fistula
- **Cardiac**
  - Cardiac Herniation
  - Cardiac Tamponade
  - Dysrhythmias (18-30% incidence)
  - Myocardial Ischemia and Myocardial Infarction
  - Platypnea and Orthodeoxia (Right to Left Shunt – patent foramen ovale)
- **Pulmonary**
  - Postpneumonectomy Pulmonary Edema (2-5% incidence)
  - Respiratory Insufficiency
  - Massive Atelectasis (7.8% incidence)
  - Postoperative Pneumonia (6-7% incidence)
  - Prolonged Air Leak
  - Bronchopleural Fistula (1-4% incidence)

Shields, General Thoracic Surgery, pgs 484-500;2000

Early Complications after Pulmonary Resection

- **Pleural**
  - Persistent Residual Air Space
  - Pleural Effusion
  - Empyema
  - Chylothorax (less than 1% incidence)
  - Esophageal Injury
- **Wound**
  - Wound infection or Dehiscence
  - Subcutaneous Emphysema
- **Thoracic Neurologic**
  - Nerve Injury: Phrenic, Recurrent Laryngeal
  - Spinal Cord Injury
  - Subarachnoid-Pleural Fistula
- **Other General**
  - Peripheral Tumor Emboli
  - DVT and pulmonary embolism (1-5% incidence)
  - Renal Failure
  - CVA
  - GI bleed

Shields, General Thoracic Surgery, pgs 484-500;2000