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**Palliative surgery for malignant pleural mesothelioma**  
Giuliano Maggi, Roberto Giobbe, Caterina Casadio and Ottavio Rena  
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## Letter to the Editor

### Palliative surgery for malignant pleural mesothelioma

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We read with interest the excellent paper of A.E. Martin-Ucar et al. [1], regarding the palliative debulking surgery for the treatment of the malignant pleural mesothelioma (MPM). We have two questions:

- (a) Were the authors able to obtain the parietal pleurectomy by VATS in all cases or was it unpractical in some patients, because the tumour was too adherent or too bleeding?
- (b) Doesn't it seem to the authors that a palliative decortication of a not expandable lung, obtained via thoracotomy, perhaps is a too severe operation, considering that the persistent air leak rate, longer than 7 days, was 15%, and the 6-week mortality rate was 14%?

In the last 3 years we performed 52 thoracotomies for MPM (pleurectomy/decortication in 14 patients and extrapleural pneumonectomy in 38 patients), but we observed only four out of 52 patients having a thin parietal pleura (7.6%).

We feel that the palliative procedures, presented in the authors' important series, are safe and feasible in a limited number of unresectable MPM, while the majority of MPM patients have a thick cortex; in these cases the parietal pleura affected by MPM is hard, sometimes very adherent to the thoracic wall tissues, with a rich vascularization which requires a meticulous and difficult coagulation: we think that these tumours are not easily resectable by VATS,

as pointed out in the discussion of Grossebner et al. [2] at the Brussels EACTS Congress in 1998.

In our experience, decortication of the visceral pleura affected by MPM is ever related with lung parenchymal damage with important air leaks, because there is never a free space between the tumour and the underlying pulmonary tissue. Air leaks and bleeding from the lung are sometimes important even if a meticulous control with stitches or glues is carried out.

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## Reply to the Letter to the Editor

### Reply to Maggi et al.

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The authors would like to thank Dr Maggi and his associates for their interest in our article recently published in the *European Journal of Cardiothoracic Surgery* [1].

We agree with some of their comments, especially related to findings during surgery. It is true that the majority of patients with malignant mesothelioma present at an advanced stage of the disease and only a limited proportion are suitable for radical surgery. However, patients present to the thoracic surgeon with symptoms, most frequently dyspnoea due to pleural effusion (100% in our series), and chest pain, probably of multifactorial cause (tumour infiltrating intercostals nerves, inflammatory reaction, effusion).

We believe that surgery has a role in the palliation of symptoms in patients with malignant mesothelioma, and that was the initial intention of our paper. Ideally we believe that this palliation by partially debulking the tumour to obtain pleural apposition should be performed by VATS

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