EDITORIAL

Thoracoscopic and video-assisted thoracoscopic operations

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Much attention has recently been focused on thoracoscopy and thoracoscopic operations, in spite of the fact that neither are new having been part of the thoracic surgical scene for over 50 yrs [1-5], albeit in a supportive diagnostic role. That the spotlight has now fallen on this area of the thoracic surgical repertory owes much to advances in videooptic technology, aided by the surgical instrument manufacturing industry. The procedure has been thrust into a starring role due to two further influences: a population clamouring for "keyhole" surgery and an increasingly cost conscious hospital management eager to pare down health care costs.

Video-assisted thoracoscopic surgery, for the classically trained thoracic surgeon, is an extension of thoracoscopy with the addition of a number of high-tech props, thus allowing expansion of its potentials.

In some countries, respiratory physicians have been the main exponents of thoracoscopy for a number of years, principally in its diagnostic capacity [5-8], and it is they who have kept thoracoscopy in the limelight. The contribution of two eminent physicians in this issue of the Journal serve to illustrate this. However, this is not to say that thoracic surgeons abandoned thoracoscopy altogether. Indeed many, whilst wholly active in the performance of the procedure, were not particularly attracted to producing publications about the technical aspects of, what they considered to be, a well-established method (as may be seen in many of the standard thoracic surgery textbooks) [10-15]. Nor did they find much to report regarding its limited therapeutic scope, which remained essentially unchanged and consisted of pleurodesis and adhesion section [16-18].

New technology has changed all this. We are now witnessing an explosion of publications related to a multitude of operations which are performed via the thoracoscopic approach [19-23]. Armed with video-assisted equipment, which allows "free-hands" and a clearer view of the thoracic cavity, thoracic surgeons are eager to expand the limits of thoracoscopy surgery. The race is on to carry out thoracoscopically every operation which may currently be performed by conventional surgical method. The review article by Loukas and Bouris [9] brings us up-to-date and gives a clear picture of the present state of indications and the role of thoracoscopy in chest diseases as seen by respiratory physicians, and as has been practised with minor variations for the last 30-40 yrs. However, it signals an important unstated message relevant to recent developments in video-thoracoscopic operations; that if the newly cloaked procedure is to offer no more than did the "old" thoracoscopy in terms of therapeutic possibilities, then this new development is no more than an upgrading of equipment with no additional benefit to patients.

If there is to be, as seems likely, expansion of thoracoscopic procedures and extension of their application, at least two issues have to be debated: 1) The role of respiratory physicians, particularly those who have traditionally performed these procedures, must be clarified. That video-assisted thoracoscopic operations should be the domain of thoracic surgeons few would doubt. The reasons are that with the extension of indications and with increasing sophistication of thoracoscopic operations, there are bound to be complications which will require immediate recognition and remedy by conventional surgical operation. There are also cases which are found to be unsuitable for thoracoscopy either during or after the event. In such cases, too, a conventional operative method will have to be undertaken. The case for surgeons undertaking video-assisted thoracoscopic operations does not, however, necessarily exclude physicians from undertaking some diagnostic procedures, but is there going to be a place for thoracoscopic operations, even diagnostic ones, being carried out in endoscopy units when other patients will be given the opportunity of having the same procedure in an operating theatre with available surgical expertise?

2) The second and even more important debate relates to the introduction of guidelines and a code of practice for video-assisted thoracoscopic operations. Admittedly, at this stage of its development the video-assisted thoracoscopic operation is on trial. That errors of judgement in its indications will be made is inevitable since there is a tremendous psychological urge by enthusiastic surgeons to perform every operation "through the keyhole". However, it is never too early for the exercise of restraint to ensure that one-upmanship does not override the patient's interest. The indication for thoracoscopic operation in any situation should be weighed carefully against the fact that such cases can be offered conventional surgical operation, which has been performed over a number of years, with minimal risks. Is it, for instance, justifiable to perform a lobectomy for cancer thoracoscopically through multiple "small holes" with much sweat for the operator and blood of the patient, despite the fact the proper nodal stations can neither be determined or adequately dealt with?

Whatever else thoracoscopy and thoracoscopic operations can or cannot achieve in the future it has presented the thoracic surgeon with a new challenge.

Whether video-assisted thoracoscopic operation is going to be, to quote Dr Johnson, "one of those meteors of fashion

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which loses its glow and burns itself out", or will be a star shining high in the sky of thoracic surgery, depends on the way this challenge is managed by the profession.

References
