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EDITORIAL COMMENTARY

Who is your plastic surgeon? The importance of an experienced reconstructive surgical colleague

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Tracheal and esophageal resections continue to present significant challenges to the thoracic surgeon. To date, there continues to be no reliable prosthesis, optimal reconstruction requires the use of autologous tissue, and failure of reconstruction leads to devastating consequences. Individually, tracheal and esophageal resection and reconstruction each have their own set of unique challenges, but when performed together, as described in the article in this issue of the *Journal* by Ghali and colleagues¹ from the MD Anderson Cancer Center, the difficulty and risk of such a combined procedure undoubtedly rise exponentially.

Ghali and colleagues¹ report a case series of 5 consecutive patients undergoing combined resection and reconstruction

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Central Message

Thoracic surgeons should proceed with complex tracheal and esophageal resections only if their plastic surgeon has reconstructive expertise.

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of the trachea and esophagus with good results, with the most complex cases being those of their patients 1 and 2. Ghali and colleagues¹ conclude that patients with pathology requiring lengthy resection of both the trachea and esophagus should not be absolutely removed from consideration as operative candidates. The article provides us with perhaps an even more important message, however: that to have any chance of success with such complex procedures, an experienced multidisciplinary team is mandatory. Thoracic surgeons are well aware that resection of the tracheal or esophageal pathology is only half the battle. Although we often perform the subsequent reconstruction ourselves, there will come a time during our careers when such standard reconstructions will clearly be suboptimal and only complex microvascular reconstructive techniques will suffice, as in situations such as those described in the current report of Ghali and colleagues.¹ No matter how successful the resection phase may be, without the support from an experienced plastic surgeon, such complex reconstructions—the second half of the battle—are doomed to failure, resulting in the ultimate loss of the war—that is, the patient.

It is essential that the thoracic surgeon be familiar with the expertise of his or her plastic surgeon, with the understanding that complex microvascular reconstructions are not for the casual plastic surgeon. A thoracic surgeon, no matter how experienced, should not consider tackling complex cases, such as those described by Ghali and colleagues,¹ unless there is full confidence in the expertise of the plastic surgical colleague. The multidisciplinary thoracic and plastic surgical team at MD Anderson is well known for their innovation and outstanding surgical

results with complex tracheal and esophageal reconstructions. In 2012, this group reported their 10-year experience with the use of a supercharged long-segment jejunal flap for esophageal reconstruction, clearly demonstrating their expertise in this area.² In addition, the senior author of the article by Ghali and colleagues,¹ Dr Yu, is well published on the subject of the anterolateral thigh flap (references 8 and 9 in the article of Ghali and colleagues¹). With such experience, it is not surprising that the MD Anderson group is able to “think outside the box” and use the anterolateral thigh free flap to create a funnel down to a very short residual trachea for reconstruction, thereby avoiding tension and the risk of great vessel erosion that is seen with other techniques of mediastinal tracheostomy.

Although this editorial focuses on the importance of an experienced plastic surgeon to the thoracic surgeon, the same undoubtedly applies to other team members involved in the care of such complex patients, including specialists in anesthesiology, specialists in critical care medicine, nurses, physical therapists, and respiratory therapists. The multidisciplinary team is only as strong as its weakest link; expertise of all these team members is essential before engaging in such “tour de force.”

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