Author has nothing to disclose with regard to commercial support.

Author has nothing to disclose with regard to commercial support.

Short-term outcomes need to be complemented by patient-centric longitudinal end points such as survival and quality of life in relation to the financial resources spent by the provider and the society to achieve those outcomes. Patient-reported outcomes, long-term survival, and costs should be recorded and analyzed in future quality-improvement initiatives along with risk-adjusted, weighted, in-hospital outcomes.

Alessandro Brunelli, MD
Department of Thoracic Surgery
St James's University Hospital
Leeds, United Kingdom

References

1. Fernandez FG, Falcoz PE, Kozower BD, Salati M, Wright CD, Brunelli A. The Society of Thoracic Surgeons and the European Society of Thoracic Surgeons general thoracic surgery databases: joint standardization of variable definitions and terminology. *Ann Thorac Surg*. 2015;99:368-76.
2. Sandri A, Papagiannopoulos K, Milton R, Kefaloyannis E, Chaudhuri N, Poyser E, et al. Major morbidity after video-assisted thoracic surgery lung resections: a comparison between the European Society of Thoracic Surgeons definition and the Thoracic Morbidity and Mortality system. *J Thorac Dis*. 2015;7:1174-80.
3. Seely AJ, Ivanovic J, Threader J, Al-Hussaini A, Al-Shehab D, Ramsay T, et al. Systematic classification of morbidity and mortality after thoracic surgery. *Ann Thorac Surg*. 2010;90:936-42.
4. Porter ME. What is value in health care? *N Engl J Med*. 2010;363:2477-81.
5. Brunelli A. Quality of care: a plea for patient perspectives and cost analyses. *J Thorac Cardiovasc Surg*. 2017;154:1404-5.

<https://doi.org/10.1016/j.jtcvs.2017.10.099>

LEFT VERSUS RIGHT To the Editor:

I enjoyed the recent article by Jung and colleagues in the July issue of the *Journal*, "Apneic Oxygen Insufflation Decreases the Incidence of Hypoxemia During One-Lung Ventilation in Open and Thoracoscopic Pulmonary Lobectomy: A Randomized Controlled Trial." Their solution to the clinical problem of hypoxemia during lung resection could prove to be a valuable option when using double-lumen endotracheal intubation. It does, however, raise a few questions.

All the patients received a left-sided double-lumen endotracheal tube. Did Jung and colleagues notice any difference in the response to the supplemental oxygen depending on left or right thoracotomy positioning? In other words, did the results vary if the supplemental oxygen was delivered through the bronchial or tracheal lumen?

Because the right lung is typically responsible for 55% to 60% of lung function, one might expect a greater percentage increase in oxygenation when supplemental oxygen was delivered to the right side. Did any of the study patients have preoperative split-lung perfusion studies that demonstrated significant variation from the usual 55% to 60% right-sided pattern? If so, did the supplemental delivery favor the side with the significantly greater baseline perfusion?

In addition, if the catheter delivering the supplemental oxygen remained within the longer bronchial lumen, this might have affected the delivery of oxygen. Did Jung and colleagues ensure that the delivery catheter was within the respective bronchus, or was the placement in the bronchus or the endoluminal position irrelevant? I am interested in Jung and colleagues' responses and compliment them on their intriguing article.

Frank A. Baciewicz Jr, MD
Department of Cardiothoracic Surgery
Michael and Marian Ilitch Department of Surgery
Wayne State University School of Medicine
Detroit, Mich

<https://doi.org/10.1016/j.jtcvs.2017.09.129>

LEFT VERSUS RIGHT Reply to the Editor:

Dr Baciewicz, thank you for your interest in our article. You asked whether the response to the supplemental oxygen was different depending on left or right thoracotomy positioning and guessed a greater increase in oxygenation when supplemental oxygen was delivered to the right side (larger lung). Your question was very interesting. Thus, we analyzed our data to get the answer.

For background explanation, we usually try left-side double lumen tube (DLT) for the right operation and right-side DLT for the left operation unless bronchial anatomy does not allow these or the surgeon requests a specific DLT. Among 45 patients in the apneic oxygen insufflation (AOI) group, left-side DLT was used for 33 patients and right-side DLT was used for 12 patients. Right thoracotomy (right AOI) was performed in 28 patients, and left thoracotomy (left AOI) was performed in 17 patients.

For your answer, the arterial partial pressure of oxygen decrease was not different between the right and left AOI (median [interquartile]: the right AOI (right thoracotomy) = -46 [-83 to -13] mm Hg, the left AOI