Author’s response to reviews

Title: The use of Ligasure Vessel Sealing System in Ivor Lewis Esophagectomy

Authors:

Fuat Sayir (sayirfuat@yahoo.com)
Ufuk çobanoğlu (drucobanoglu@hotmail.com)
Abidin Şehitoğulları (abidin_sehitoglu@yahoo.com)

Version: 2 Date: 10 January 2012

Author’s response to reviews: see over
Answers to Reviewer comments:

1. The abbreviation was made in the introduction section. These sentences were removed from the introduction section: In light of recent technological developments, minimally invasive surgical procedures started to be used in surgical treatment of esophageal cancer. In this sense, the technological tools that are used provide maximum efficiency for surgical treatment.

2. The aim of the study emphasized and added to the introduction section. The aim is stated as follow: We were intended to evaluate whether the use of LVSS technique in esophagectomy would improve advantages compared with the conventional surgical procedure of esophageal cancer.

3. Current surgical techniques in recent years is stated as follow at the discussion section: Over the past decade there have been many significant changes in the management of esophageal cancer. Several surgical procedures are available to resect esophageal carcinoma and restore the digestive system. The surgical procedures are based on concepts sometimes radically opposed with respect to the carcinologic approach: from transhiatal esophagectomies without node resection as described by Orringer et al. (1) to en block resections supported by Skinner (2). To date Akiyama et al. (3) described the three-field colo-thoraco-abdominal lymph node dissection. Ivor Lewis procedure (4) combines an extended resection of the esophagus with either standart or extensive thoracic and abdominal lymph node dissection. Western and Eastern countries cause various attitudes on their surgical management. In addition to the above surgical approaches recently reported thoracoscopic approach (5). Minimally invasive esophagectomy by thoracocopy, laparoscopy, and servicotomy has been described by several authors (6). Recently, Cadiere et al. (6) has been described Ivor Lewis esophagectomy with manuel esogastric anastomosis by thoracocopy in prone position and laparoscopy. With this technique, less pain, shorter hospital stay, rapid recovery was achieved. David EA et al. (7) modified a thoracoabdominal positioning for Ivor Lewis esophagectomy. In addition to this hybrid position, they also use a vertical mid-axillary thoracotomy fort he thoracic approach. This technique is useful for a number of reasons. This position allows for simultaneous manipulation within both cavities for delivery of the conduit. Campos et al. (8) have found that constructing a circular-stapled anastomosis with the trans-oral anvil allows for a standardised esophago-gastric anastomosis. This is a straightforward and reproducible technique that is particularly suited to the minimally invasive thoracocopic approach, and has a low leak and stricture rate.

There are new surgical techniques and surgical approach. Surgical technique is an important factor in preventing intraoperative and postoperative complications. For example recently, the use of self expandable metallic coated stents resulted in considerable improvements of thoracic anastomotic leaks (9). Also, supporting the anastomosed region with omentum, pleura, pericardium, and fat tissue further decreases anastomotic leaks. The use of LVSS, reduced perioperative bleeding and prevent unplanned splenectomy.

4. English grammar corrections were made and shown in the text with red colour.