Reviewer's report

Title: Two-port approach for fully thoracoscopic right upper lobe sleeve lobectomy

Version: 1 Date: 12 March 2013

Reviewer: ATSUSHI WATANABE

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Major Compulsory Revisions

# I think that an endostapler and a 10mm endoscopy cannot pass through a 10mm incision port. The 10mm incision can make only 20mm circumference and about 7mm port in diameter. The 10 mm incision should be revised to 15mm.

# In the text, the authors described “The 30° camera and the endostaplers are exchanged from one incision to the other for the resection of the superior pulmonary vein.” “Superior” is misspelled. This is a report on right upper sleeve lobectomy, and the veins (V4+5) inflowing from the right middle lobe must have been preserved. “Superior pulmonary vein” should be revised to “right upper lobe pulmonary veins”.

# There are no descriptions about the length of resected bronchus. How many bronchial rings or how long was the resected right bronchus? This should be described in the text.

# Running sutures with two 3-0 Vicryl was used to anastomose the bronchus. Are these anastomosis methods and materials the same as sleeve lobectomy by thoracotomy? We usually use interrupted sutures for anastomosis of the cartilage portion and a 4-0 suture. Are running suture and needle size of suture important issues for thoracoscopic sleeve lobectomy?

# The authors described that it took 60 minutes to perform the bronchial anastomosis. As likely as not, anastomosis time is about twice as that by thoracotomy. I suppose that the prolonged anastomosis time may predispose the patients to infection.

# I think that during the bronchial anastomosis, the right main pulmonary artery was a hindrance to the anastomosis procedure. Therefore, oppression or retraction of the right pulmonary artery was required in order to obtain a good thoracoscopic view and for access of the needle holder and forceps in and out. From what port and how was pulmonary artery oppression or retraction performed?

# In the section of discussion, it is described that in our literature review, we have found no reports of sleeve lobectomy performed through a two-port. Surely, this is the first case report on sleeve lobectomy by two-port thoracoscopic surgery. Is there any demerit or disadvantage in sleeve lobectomy by two-port thoracoscopic surgery? We have no reports on the less invasiveness of two-port VATS to consider superiority over three- or four-port VATS.
Minor Essential Revisions

# In the text, the authors described “The 30°camera and the endostaplers are exchanged from one incision to the other for the resection of the superferior pulmonary vein.” “Superferior” is misspelled. This is a report on right upper sleeve lobectomy, and the veins (V4+5) inflowing from the right middle lobe must have been preserved. “Superferior pulmonary vein” should be revised to “right upper lobe pulmonary veins”.

# There are no descriptions about the length of resected bronchus. How many bronchial rings or how long was the resected right bronchus? This should be described in the text.

# In the text, a description is as follows: “Initially, a distinct air leakage by the side of the knot was detected when setting a normal saline and 20 mm Hg ventilation positive end-expiratory pressure.” Is 20 mmHg PEEP correct? I think it is 20 cmH2O.

**Level of interest:** An article of limited interest

**Quality of written English:** Acceptable

**Declaration of competing interests:**

'I declare that I have no competing interests' below