For EBSLN monitoring, the intact function of the entire EBSLN must be ensured by the stimulation of the most superior and caudal aspect of the exposed EBSLN. Indirect stimulation of the EBSLN by vagal nerve stimulation may be impracticable in routine thyroidectomies as it may require more dissection in the neck, but it may be possible in the case of lateral compartment lymph node clearance. The intact function of the EBSLN must be assessed after complete thyroidectomy and hemostasis.

For all those reasons, IONM has different potential implications in the EBSLN; clinically there is a better identification and monitoring, from a research (electromyographic amplitude of the cricothyroid muscle), educational (for training in identification of the nerve), and legal (for professional speakers) point of view.

We agree with the conclusions of this study; stroboscopy is mandatory to evaluate if neuromonitoring decreases the frequency of the EBSLN injury, but we would like to point out a final statistical consideration regarding the experimental design of this paper. It does not seem that the authors have performed an a priori sample size calculation, and they do not state the endpoint at which an anticipated difference could be observed. We understand that an impairment of the neural function of the external branch of the superior laryngeal nerve during thyroidectomy is a rare event, and it is not easy to enroll a sufficient number of patients, but reaching an adequate statistical power (= an adequate sample size) is a mandatory step to drawing adequate conclusions about prospective randomized trials or whenever statistical tests are used to detect differences among different kind of approaches. An extension of this study in a prospective multicenter randomized trial would be a very interesting project.

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Re: “Outcomes of elective abdominal aortic aneurysm repair among the elderly: Endovascular versus open repair”

To the Editors:
We have read with great interest the report by Raval and Eskandari1 describing the national outcome data.
after open (OSR) and endovascular repair (EVAR) of elective abdominal aortic aneurysms (AAA) in octogenarians. They describe one of the largest series of octogenarians with AAA and report a significant better overall morbidity and mortality in patients <80 years. Furthermore, octogenarians were more likely to be treated by EVAR, which resulted in a significantly better morbidity and mortality compared with OSR. In our centers, we also treat octo- and nonagenarians with AAA, both in the elective and acute setting. For the most part, we agree with the authors; however, 2 important questions remain unanswered: (1) Do their conclusions also apply to octogenarians experiencing acute AAA? and (2) Where is the limit for treatment with regard to age?

In a recent study focusing on octogenarians with acute AAA, we found a median survival of >2.8 years for octogenarians, although intensive care (ICU) and hospital durations of stay were not prolonged compared with younger patients (mean ICU stay, 6.9 ± 11.5 days for patients <80 years and 5.7 ± 7.8 days for octogenarians [P = .33]; mean hospital stay, 16.9 ± 20.4 days for patients <80 years and 13.7 ± 16.7 days for octogenarians [P = .11]). We observed no differences in procedure- and disease-related complications between the 2 groups. Consistent with the results by Raval and Eskandari, we found a significant difference in hospital and ICU durations of stay, and in-hospital and overall mortality in favor of EVAR compared with OSR. Unfortunately, Raval and Eskandari do not report on the outcome of acute AAAs. Especially in acute cases, advanced age may be considered a contraindication to further treatment, especially when EVAR is not feasible, leaving OSR the only treatment option.

Despite the reported good results, we feel that there are limits to the usefulness of treatment in the elderly. Although age alone is not a reason to refrain from treatment, current evidence merely confirms that octogenarians may be safely treated by EVAR. But where are the limits and what happens if we include nonagenarians? Two recent publications dealing with this issue concluded that, despite advanced age, these patients do benefit from intervention at very acceptable morbidity and mortality rates. However, all patients who presented with an acute AAA died after treatment. It, therefore, seems that age per se is far less important than, for example, the biological condition of the patients, which is drawn from the severity and quantity of both the disease and comorbidities.

One must conclude that there are certainly upper limits to the treatable age and they are mainly determined by urgency and treatment options, in this case, suitability for EVAR. Although octo- and nonagenarians, in an elective setting, an acceptable survival may be achieved after OSR, this does not apply to emergent cases and should therefore be discouraged in these situations.

References

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