Feasibility of video-assisted thoracoscopic sleeve lobectomy for non-small cell lung cancer

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ABSTRACT

Purpose: Sleeve lobectomy is a safe and effective surgical procedure for centrally located non-small cell lung cancer (NSCLC). However, the use of video-assisted thoracoscopic surgery (VATS) on bronchial sleeve resection is still controversial due to a lack of evidence. In this study, we describe our experience on VATS sleeve lobectomy and evaluate its feasibility for treating NSCLC.

Methods: From January 2010 to May 2019, VATS sleeve lobectomy was attempted in 19 patients with NSCLC at Samsung Medical Center. Their baseline characteristics, perioperative data, and survival outcome were collected and analyzed retrospectively.

Results: Of the 19 patients, 10 underwent VATS sleeve lobectomy successfully. The mean age of the patients who underwent successful VATS was 53.5 ± 15.8 years, and all the patients were men. Seven patients (70%) had squamous cell carcinoma. The mean postoperative chest tube drainage duration was 5.3 ± 2.3 days, and the median hospital stay duration was 7 days (interquartile range, 6.25 to 11.5 days). Among the patients who underwent successful VATS, two had postoperative bronchial stenosis: One patient underwent complete pneumonectomy, and one patient was observed without any intervention. During the median follow-up duration of 3.5 years, two patients with squamous cell carcinoma who underwent successful VATS died. Of these, one died 70 days postoperatively because of acute respiratory distress syndrome and one died 18 months postoperatively from an unknown cause. No patient had locoregional recurrence.

Conclusion: VATS sleeve lobectomy is a feasible surgical procedure for centrally located tumors without vascular invasion.

Keywords: Carcinoma, non-small-cell lung; Sleeve lobectomy; Thoracic surgery, video-assisted

INTRODUCTION

Sleeve lobectomy is a safe and effective surgical option for centrally located non-small cell lung cancer (NSCLC) that not only prevents the risk of incomplete resection of the tumor but also preserves pulmonary function by avoiding pneumonectomy. Many studies have shown
that sleeve lobectomy is not inferior to pneumonectomy with regard to long-term survival, quality of life, and postoperative risks [1-6]. Thoracotomy has been the standard approach for sleeve bronchial resection due to its complexity and difficulty and the risk of postoperative bronchial complications. However, with increasing experience and technique advances in performing video-assisted thoracoscopic surgery (VATS), the use of VATS is expanding to more complicated cases including sleeve lobectomy. Since the first case report on the use of VATS sleeve lobectomy, published in 2002 [7], it has been used steadily by some thoracic surgeons [8-11]. Some retrospective studies have shown that VATS sleeve lobectomy is a safe and feasible surgical procedure for treating centrally located NSCLC with comparable perioperative and survival outcomes to the thoracotomy approach [12-16]. However, the application of VATS in bronchial sleeve resection is still controversial due to a lack of evidence.

Thus, in this retrospective study, we describe our experience on VATS sleeve lobectomy and evaluate its feasibility for treating centrally located NSCLC.

METHODS

Patient selection
From January 2010 to May 2019, VATS sleeve lobectomy was attempted in 19 patients with NSCLC by a single surgeon at Samsung Medical Center. Data associated with the patients’ baseline characteristics, operative details, perioperative course, survival, and recurrence were collected from the medical records. Postoperative pathological staging was performed according to the eighth edition of the tumor–node–metastasis (TNM) classification by the International Association for the Study of Lung Cancer.

For the preoperative evaluation, physical examination, chest radiography, contrast-enhanced chest computed tomography (CT), positron emission tomography, and pulmonary function tests were performed in all patients. Moreover, bronchoscopic evaluation was performed when the tumor was suspected to invade the bronchus. For mediastinal nodal staging, mediastinoscopy or endobronchial ultrasound-guided transbronchial needle biopsy was performed. If N2 disease was confirmed by biopsy, the patient underwent neoadjuvant chemoradiation therapy followed by surgery. Adjuvant therapy was recommended for patients with pathologic stage II or III NSCLC or positive resection margin. After surgery, patients regularly visited the hospital for recurrence surveillance. Chest CT was performed every 3 to 6 months.

The study was approved by the Institutional Review Board (IRB No. 2020-11-120) of Samsung Medical Center, and informed consent was waived.

Surgical procedure
General anesthesia with one-lung ventilation was induced using a double-lumen endotracheal tube. The patients were placed in a lateral decubitus position. For the VATS approach, a utility port was placed in the fifth intercostal space (ICS) and one or two additional ports were made in the seventh or fourth ICS as needed. The surgeon operated on the right side of the operating table regardless of patient positioning (either left or right lateral decubitus). An assistant using a thoracoscope routinely stood opposite the surgeon and rotated the camera head 90° toward the surgeon. This positioning provided the assistants a view consistent with conventional thoracotomy. The surgeon’s monitor was rotated 180° (upside down) to provide the same orientation as seen in open thoracotomy. This setting of orientation and monitoring system provided good ergonomics and comfortable handling (Fig. 1).

For the bronchial sleeve resection, the main bronchus and lobar bronchus were skeletonized after dissecting the lymph nodes. The main bronchus and bronchus of the reserved lobe were cut off 1 cm from the tumor margin. After the negative margins were confirmed on frozen biopsy, bronchial...
anastomosis was performed. Simple interrupted sutures with three or four inner knots or simple continuous sutures were placed in the posterior side; then, multiple outer knots were placed in the anterior and lateral sides. Fibrin sealant was applied to the anastomosis site for reinforcement. After the bronchial anastomosis, an air leakage test of the bronchus was conducted using normal saline to confirm that no air leakage was present under 20 cm H\textsubscript{2}O airway pressure.

**Statistical analysis**

The patients’ baseline characteristics and perioperative outcomes including the number of resected lymph nodes, operating time, duration of intensive care unit and hospital stay, and duration of postoperative chest tube drainage were analyzed using SPSS version 25 (IBM Corp., Armonk, NY, USA). The measurement data were expressed as mean ± standard deviations. The overall and recurrence-free survival rates were evaluated using Kaplan–Meier curve analysis.

**RESULTS**

**Patient characteristics**

The baseline characteristics of the 10 patients who underwent successful VATS sleeve lobectomy are described in Table 1. The mean age of the patients undergoing successful VATS was 53.5 ± 15.8 years, and all patients were male. The patients who underwent successful VATS had tumors located in the left upper (n=6), left lower (n=3), and right upper lobes (n=1). In addition, the clinical TNM staging were T1 (n=3), T2 (n=7), N0 (n=6), N1 (n=3), and N2 (n=1).

The characteristics of the 19 patients for whom VATS sleeve lobectomy was attempted are shown in Supplementary Table 1. The mean age of the patients was 59.7 ± 14 years, and most patients (89.5%) were male. Tumors were located in the left upper (n=12), right upper (n=4), and left lower lobes (n=3). The clinical TNM staging was as follows: T1 (n=3, 15.8%), T2 (n=15, 78.9%), and T3 (n=1, 5%) and N0 (n=11, 57.9%), N1 (n=7, 36.8%), and N2 (n=1, 5%). No patient had a history of receiving neoadjuvant treatments.

**Surgical outcomes**

Among 19 patients for whom VATS was attempted, nine patients (47.4%) were converted to thoracotomy. The main reason for the conversion was tumor invasion to the main pulmonary artery that required vascular sleeve operation (n=5). Other reasons were failure of the one-lung ventilation (n=2), anthracofibrotic lymph node (n=1), and insufficient resec-

**Table 1. Characteristics of patients undergoing VATS sleeve lobectomy**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Successful VATS (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>53.5±15.8</td>
</tr>
<tr>
<td>Male sex</td>
<td>10 (100)</td>
</tr>
<tr>
<td>Smoking history</td>
<td></td>
</tr>
<tr>
<td>Never smoker</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Pulmonary function test</td>
<td></td>
</tr>
<tr>
<td>FEV1 (%PRED)</td>
<td>84.9±10.3</td>
</tr>
<tr>
<td>DLCO (%PRED)</td>
<td>85.6±15</td>
</tr>
<tr>
<td>Comorbidities</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Previous malignancy</td>
<td>0</td>
</tr>
<tr>
<td>CCI score</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2 (20)</td>
</tr>
<tr>
<td>1</td>
<td>7 (70)</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>≥3</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Tumor location</td>
<td></td>
</tr>
<tr>
<td>RUL</td>
<td>1 (10)</td>
</tr>
<tr>
<td>LUL</td>
<td>6 (60)</td>
</tr>
<tr>
<td>LLL</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Clinical T stage</td>
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</tr>
<tr>
<td>T1</td>
<td>3 (30)</td>
</tr>
<tr>
<td>T2</td>
<td>7 (70)</td>
</tr>
<tr>
<td>T3</td>
<td>0</td>
</tr>
<tr>
<td>Clinical N stage</td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>6 (60)</td>
</tr>
<tr>
<td>N1</td>
<td>3 (30)</td>
</tr>
<tr>
<td>N2</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

Values are presented as mean±standard deviation or number (%). VATS, video-assisted thoracosurgical surgery; FEV1, forced expiratory volume in 1 second; PRED, predicted; DLCO, diffusing capacity for carbon monoxide; CCI, Charlson comorbidity index; RUL, right upper lobe; LUL, left upper lobe; LLL, left lower lobe.

Postoperative pathological examination indicated that of the patients who underwent successful VATS: seven had squamous cell carcinoma, two had mucopidermoid carcinoma, one had atypical carcinoid tumor.
Furthermore, in these patients, the mean operative duration was 236±79 minutes from the time of skin incision to wound closure, and the mean number of lymph nodes dissected was 16.7±7.9 per patient. In addition, complete resection was achieved in all patients, and the mean length of bronchial resection margin was 0.7±0.5 cm in patients with successful VATS.

In patients who underwent VATS successfully, the mean postoperative chest tube indwelling time was 5.3±2.3 days, and the median hospital stay duration was 7 days (interquartile range, 6.25 to 11.5 days). Pathological and operative data have been summarized in Table 2. Two patients had postoperative bronchial stenosis. One of these underwent completion pneumonectomy, and one was observed without any intervention. The postoperative complications that were observed in the cohort are shown in Table 3.

The perioperative outcomes and complications of patients for whom VATS sleeve lobectomy was attempted are described in Supplementary Tables 2, 3.

**DISCUSSION**

The VATS approach has been widely adopted in treating NS-CLC. Compared to open thoracotomy, VATS had many advantages including reduced postoperative pain, preserved
l lung function, reduced hospital stay duration, and reduced postoperative chest tube drainage duration [17-19]. Nevertheless, the use of VATS in patients with centrally located lung cancer who need sleeve bronchial resection is still controversial because of oncological efficacy and because it is technically demanding. With technological advances in surgical instruments, high-resolution cameras, and three-dimensional systems, several authors have successfully performed VATS sleeve lobectomy [20-23].

This study evaluated the feasibility and oncological outcome of VATS sleeve lobectomy. In terms of postoperative outcomes, including the duration of chest tube drainage, hospital stay duration, and incidence of complications, the outcomes of this study conform to the literature on conventional thoracotomy [12,24]. Recently, Gao et al. [12] have reported that VATS sleeve lobectomy was associated with less blood loss, shorter chest tube drainage duration, and shorter postoperative hospital stay duration. Moreover, Yang et al. [14] have shown that patients who underwent VATS sleeve lobectomy had a lower incidence of postoperative complications and lesser duration of postoperative thoracic drainage.

Regarding oncological results, in this study, the 5-year overall survival rate of all patients who underwent successful VATS was 80%, whereas that of patients with squamous cell carcinoma was 71.4%. Furthermore, the 5-year recurrence-free survival rate of patients with squamous cell carcinoma was 40%. The main concern about the use of VATS in sleeve bronchial resection is local recurrence. This study showed that the local recurrence rate after VATS sleeve resection was 0%. These survival and recurrence outcome were comparable to the outcomes of conventional sleeve lobectomy in the literature [1,5,12,14,15,24,25]. In 2013, Kasprzyk et al. [26] have reported that the 5-year survival rate after conventional sleeve lobectomy was 56.1%, and the local recurrence rate was 9.3%. In 2009, Merritt et al. [24] have shown that the 5-year survival rates for patients who underwent conventional sleeve lobectomy for pathological N0 and N1 NSCLC were 52.6% and 39.3%, respectively. Furthermore, in 2015, Zhou et al. [13] have demonstrated that the overall 1-, 3-, and 4-year survival rates of patients who underwent VATS sleeve lobectomy were 100%, 73%, and 40%, respectively. For those who underwent thoracotomy, the overall 1-, 3-, and 4-year survival rates were 100%, 63%, and 56%, respectively.

The rate of conversion to thoracotomy was high (9/19, 47.4%) in this study. The main reason for the conversion was tumor invasion to the main pulmonary artery requiring vascular sleeve operation (5/9, 55.6%). When the vascular sleeve procedure was needed, we preferred to convert to thoracotomy for safe and accurate anastomosis of the vessels. In the VATS approach, there is generally limited space for instrumentation to allow clamping and anastomosis of the main pulmonary artery; thus, operation time is much increased. Prolonged duration for main pulmonary artery clamping and anastomosis may cause ischemia-reperfusion injury or interstitial/alveolar pulmonary edema. If tumor invasion to the main pulmonary artery is strongly suspected on preoperative imaging studies, immediate thoracotomy rather than VATS may reduce the conversion rate to thoracotomy in this series.

The operative time of VATS sleeve lobectomy was long, probably due to the more challenging and complicated operative techniques associated with VATS. During thoracoscopic sleeve lobectomy, one of the technical challenges is related to bronchial anastomosis. We traditionally have applied simple interrupted sutures with three or four inner knots for the membranous part of the bronchus and multiple outer knots for the cartilage part. Recently, we applied simple continuous sutures for the membranous part combined with simple interrupted sutures for the cartilage part. The change from interrupted sutures to continuous sutures for the membranous part shortened the operative time.

This study has several limitations. First, it was a retrospective study and there could be a treatment selection bias. Although VATS sleeve lobectomy achieved outcomes comparable to those of open surgery in this study, the selection bias for VATS sleeve lobectomy may have improved the outcome. Second, the information for VATS indication is insufficient. In addition, it included a relatively small number of patients from an experienced surgeon. VATS was performed only in few patients because of the relatively narrow indication of VATS for sleeve lobectomy. If our experience accumulates, the inclusion criteria could be expanded. Third, this was a single-arm study with a relatively short-term follow-up. Future prospective studies that compare VATS with open thoracotomy need to be conducted to validate the efficacy of VATS.

Despite these limitations, we showed that the outcomes of VATS sleeve lobectomy were comparable to those of conventional sleeve lobectomy that have been document in the literature. Our surgical technique and real-world practice about VATS sleeve lobectomy are informative for most surgeons who perform minimally invasive procedures.

In conclusion, performing sleeve lobectomy using the VATS approach is feasible and safe without compromising the on-
cological efficacy. In this series, the main reason for conversion to thoracotomy was tumor invasion to the main pulmonary artery that necessitated vascular sleeve operation. If vascular invasion of the tumor is strongly suspected preoperatively, planning thoracotomy rather than VATS may reduce the conversion rate to thoracotomy.

**CONFLICTS OF INTEREST**

No potential conflict of interest relevant to this article was reported.

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Acquisition, analysis, or interpretation of data: YJJ, JY, YSC, MSK, JWC.  
Drafting the work or revising: YJJ, JY, YSC.  
Final approval of the manuscript: YJJ, JY, YSC, MSK, JWC.

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