Thoracoscopic pneumonectomy without tracheal intubation has not been reported. We describe a woman with severe bullous emphysema of the right upper lobe and hypoplasia of the remaining lung lobes who underwent thoracoscopic pneumonectomy using a nonintubated anesthetic technique of internal intercostal nerve block, vagal block, and targeted sedation. The successful results in this patient suggest that nonintubated thoracoscopic pneumonectomy is technically feasible and can be used in a specific group of patients.
Tubeless uniportal thoracoscopic surgery for peripheral lung nodules
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Introduction:
Endotracheal intubation and chest tube drainage are considered mandatory for thoracoscopic pulmonary resection. Management of peripheral lung nodules using tubeless uniportal thoracoscopic surgery has not been reported previously.

Materials and Methods:
From October 2015 through January 2016, 30 consecutive patients with peripheral lung nodules underwent uniportal, thoracoscopic wedge resection without endotracheal intubation and chest tube drainage (tubeless group). The clinical outcomes were compared with 30 consecutive patients with peripheral lung nodules who underwent uniportal, thoracoscopic wedge resection with chest tube drainage from April through October 2015 (chest tube group).

Results:
The demographic, anesthetic, and operative characteristics of the patients were comparable in both groups. No major complications occurred following surgery. A small residual pneumothorax was noted in 12 (40.0%) at 6 hours and day 1 and in 2 (6.6%) patients on day 14 in the tubeless group. No patient required reintervention or readmission to the hospital. Patients in the tubeless group had lower pain scale scores on postoperative day 1 (mean, 1.0 vs. 1.5, \(P = 0.012\)) and shorter postoperative hospital stays (mean, 3.1 days vs. 4.4 days, \(P = 0.011\)) compared with the chest tube group.

Conclusion:
Tubeless uniportal, thoracoscopic wedge resection is feasible and safe and may be a less invasive alternative for managing selected patients with peripheral lung nodules.
Comparison of single and multi-incision minimally invasive esophagectomy (MIE) for treating esophageal cancer: a propensity-matched study

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Purpose:
To compare the perioperative outcome of minimally invasive (MIE) esophagectomy performed with a single or a multi-incision in treating esophageal cancer.

Materials and Methods:
Patients with esophageal cancer who underwent MIE from 2006 to 2016 were evaluated. A 3-4 cm incision was created both in the thoracoscopic and the laparoscopic phases during the single-incision MIE procedures. A propensity-matched comparison was made between the two groups of patients.

Results:
We analyzed a total of 48 pairs of patients with propensity-matched from the cohort of 360 patients undergoing MIE during 2006-2015. There is no statistical difference in terms of postoperative ICU and hospital stay, number of dissected lymph nodes and presence of major surgical complications (anastomotic leakage and pulmonary complications) between the two groups of patients. The pain score one week after surgery was significantly lower in the single-incision group (P<0.05). There was no surgical mortality in the single-incision MIE group.

Conclusion:
Minimally invasive esophagectomy performed with a single-incision approach is feasible for treating patients with esophageal cancer, with a comparable perioperative outcome with that of multi-incision approaches. The postoperative pain one week after surgery was significantly reduced in patients undergoing single-incision MIE.
Hepatoesophageal Fistula After Radiofrequency Ablation for Hepatic Metastasis

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Although surgical resection remains the treatment of choice for hepatic tumors, radiofrequency ablation has emerged as a reliable alternative. Radiofrequency ablation is both less invasive and can be repeated after short intervals in cases of multiple lesions that cannot be treated with surgical resection. Liver abscess, which may progress to internal enteral fistula, is the most common complication of radiofrequency ablation. Here we present the first case report in the literature of a rare complication of hepatoesophageal fistula after radiofrequency ablation for colon cancer with liver metastasis. This case was well managed with percutaneous abscess drainage, antibiotics, and separation of the hepatoesophageal fistula using an esophageal stent.
Predictors of Survival in Esophageal Squamous Cell Carcinoma with Pathologic Major Response after Neoadjuvant Chemoradiation Therapy and Surgery: The Impact of Chemotherapy Protocols

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Purpose: Tumor recurrence is an important problem threatening esophageal cancer patients after surgery, even when they achieve a pathologic major response (pMR) after neoadjuvant concurrent chemoradiation therapy (CCRT). The predictors related to overall survival and disease progression for these patients remain elusive. We aimed to identify factors that predict disease progression and overall survival in esophageal squamous cell carcinoma (SCC) patients who achieve a pMR after neoadjuvant CCRT followed by surgery.

Materials and Methods: We conducted a retrospective study to analyze the factors influencing survival and disease progression after esophagectomy for esophageal cancer patients who had a major response to CCRT, which is defined by complete pathological response or microscopic residual disease without lymph node metastasis.

Results: From our study cohort, 285 patients underwent CCRT and subsequent esophagectomy; 171 (60%) of these patients achieved pMR. After excluding patients with lymph node metastases, incomplete clinical data, and adenocarcinomas, we enrolled 117 patients in this study. We found that the CCRT regimen was the only factor that influenced overall survival. The overall survival of the patients receiving taxane-incorporated CCRT was superior to that of patients receiving traditional cisplatin and 5-fluorouracil (PF) (P=0.011). The CCRT regimen can significantly influence the clinical outcome of esophageal SCC patients who achieve pMR after neoadjuvant CCRT and esophagectomy.

Conclusion: Incorporation of taxanes into cisplatin-based CCRT may be associated with prolonged survival.