Letter to the Editor

To The Editor: I wish to comment on the most recent issue of **Neurosurgical Focus**, specifically the article on thoracoscopic approaches to sympathectomy. I have performed T-2 ganglionectomy via a limited costotransversectomy on many occasions and published a series in **Spine** in 1990. This procedure does not require collapse of a lung or a chest tube. The incision required is only 4 in long. Bilateral procedures can be performed through the same incision without difficulty. Patients leave the hospital to go home the next day. A limited costotransversectomy is not very technically demanding. The thoracoscopic procedure is very demanding and requires the presence of a thoracic surgeon.

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Response: The authors wish to thank Dr. Fedder for his comments regarding our recent article on thoracoscopic sympathectomy and for describing his experience[1]. We also have had experience performing the posterior T-2 sympathetic ganglionectomy procedure via a limited costotransversectomy that he described and have had good success. Our shift away from ganglionectomy via this approach toward endoscopic procedures was motivated by several reasons, which included shorter duration of incisional pain for the patient, no soft-tissue retraction unlike that required to facilitate a wide paraspinal exposure, and better visualization of the paraspinal region making tissue confirmation easier. Visualization and confirmation of the anatomy endoscopically is very obvious. Postoperatively, we use only No. 20 French chest tubes, which cause minimal discomfort, and can be removed sequentially the same day. We find the administration of oral analgesics to be quite adequate. We are also able to reset additional ganglia (that is, T-3 and T-4), if necessary, that may improve sympathetic denervation of the upper extremity.

I fully agree that there is a significant learning curve for mastering endoscopic techniques but this diminishes with experience. I also must admit that new technology is appealing and further assessment is needed to evaluate the efficacy of these techniques.[2,3]

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References

1. Fedder SL: T2-ganglionectomy via limited costotransversectomy for minor causalgia. **Spine** 15:269-270, 1990

2. Johnson JP, Ahn SS, Choi WW, et al: Thoracoscopic sympathectomy: techniques and outcome. **Neurosurg Focus** **4 (2)**:Article 4, 1998
 3. Hashmonai M, Kopelman D, Schein: Thoracoscopic versus open supraclavicular upper dorsal sympathectomy; a prospective randomized trial. **Eur J Surg (Suppl)** **572**:13-16, 1993
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