Sixth International Joint Meeting on THORACIC SURGERY

Barcelona - 20th, 21st and 22nd November 2024
Auditorio Foment del Treball Nacional. Barcelona (Spain)

11th International Meeting on General Thoracic Surgery
Clínic Barcelona | Universitat de Barcelona | Hospital Universitari Sagrat Cor

5th Meeting of the Thoracic Oncology, Thoracic Surgery, Techniques & Transplant, Respiratory Nursing and Respiratory Physiotherapy Areas of the Spanish Society of Pneumology and Thoracic Surgery (SEPAR)
Sociedad Española de Neumología y Cirugía Torácica (SEPAR)

10th International Workshop on Surgical Exploration of the Mediastinum and Systematic Nodal Dissection
Hospital Universitari Mútua Terrassa | Universitat de Barcelona

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3rd Joint Meeting of the Spanish Society of Thoracic Surgery (SECT)
SECT Sociedad Española de Cirugía Torácica

30th Congress of the "Asociación Iberoamericana de Cirugía Torácica" AIACT

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PERICARDIAL WINDOW FOR MALIGNANT PERICARDIAL EFFUSION: THE VIDEO-ASSISTED THORACOSCOPIC APPROACH

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*Malignant pericardial effusion(MPE) has a particularly poor prognosis due to advanced disease requiring palliative treatment. Pericardial window(PW) has a double interest: a pericardial lifesaving drainage and performing biopsies as part of the etiological assessment of pericardial effusions. *Study the surgical management particularities of MPE. *A retrospective series of 13cases of MPE operated on at the thoracic surgery department of Abderrahmen Mami Ariana Hospital over 15years-period. *The average age was 45years with a sex-ratio of0.4. The main symptom was thoracic pain(n=8). We included patients with echocardiographically documented malignant pericardial effusion requiring further diagnosis(n=7) or relief of tamponade symptoms(n=7), or patients with persistent or recurrent effusions after percutaneous drainage(n=3). None of the patients was hemodynamically compromised. The perioperative risk depended on the generally altered condition of the patient and the hemodynamic tolerance of the MPE after installation of the patient. The approach was a video-assisted mini-thoracotomy(n=4) and an exclusive video-thoracoscopy(n=9). The procedure consisted on evacuation of the pleural effusion with creation of a PW with careful protection of the phrenic nerve. A pericardial and pleural biopsy followed by applying talc under direct vision avoiding the mediastinal part of the chest cavity. One case of post- operative death by cardiorespiratory arrest was noted. At the 3-month postoperative follow-up, symptoms were alleviated in all surviving patients. Echocardiography showed no recurrent pericardial effusion. *Performing a pericardial window is increasingly proving its interest in the management of MPE. However, a good assessment of the perioperative risk in these patients is mandatory to minimize the perioperative morbi-mortality.