

Thymectomy has long been the mainstay treatment for thymoma and other anterior mediastinal neoplasms, with radiation and chemotherapy as the adjuvant therapy (1). In recent years, minimally invasive thymectomy (MIT) has been reported to be an effective surgical approach involving less trauma, shorter hospital stay, potentially fewer complications, and rapid recovery; it has become an important way to treat thymic tumors (2). The past decade has also witnessed an increasing application of video-assisted thoracoscopic surgery (VATS) and robotic surgery in the field of thymoma. In this book, *Minimally Invasive Thymectomy*, the international leading experts in the field were gathered to provide the state-of-the-art research on VATS thymectomy and robotic thymectomy.

The book includes three sections relating to the following topics: minimally invasive thymectomy, VATS thymectomy, and robotic thymectomy. In the first section, six articles from Turkey, USA, and Italy aim to give an overall description of MIT. The paper by Dr. Toker provides standardized definitions and policies of MIT, which may help to better understand the major benefits, requirements, limits, and future value of MIT. The article on the Mayo Clinic experience of MIT may help readers get to know MIT from an international perspective. The next paper's purpose is to compare MIT with open thymectomy from the standpoint of surgical techniques, patient demographics, and perioperative outcomes. The following three articles further discuss the substantial changes of surgical treatment for thymic tumors and the role of MIT.

The video imaging technique was introduced in late 1980s, which facilitated the introduction of VATS thymectomy in the beginning of the 1990s (3,4). Compared with other surgical approaches, VATS thymectomy allows complete resection of the gland as well as extended operations, with less postoperative pain, good cosmesis, and better quality of life. Therefore, VATS thymectomy has been widely used in centers worldwide for treating thymic tumors. In the second section of the book, 27 articles by distinguished experts from 15 countries provide a comprehensive review of VAT thymectomy.

When it comes to MIT, it is necessary to mention robotic thymectomy, and this topic is treated in the last section of the book. The first robotic thymectomy was performed by Dr. Yoshino's team in 2001, while the first series of patients undergoing robotic thymectomy was described by Dr. Ashton in February 2003 and Dr. Rea in March 2003 (5-7). From then on, robotic assistance has been used more frequently in the operation of thymectomy. With robotic assistance, surgeons can perform precise movements and dissection more intuitively and easily. Meanwhile, the patients undergoing robotic thymectomy also benefit from shorter hospital stay and quicker recovery.

We hope that this excellent compilation of highly focused chapters will provide the surgeons and other interesting readers a deeper insight into MIT.

References

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