

## AB022. LA07. Is there a threshold for getting over the learning curve for minimally invasive surgery for thymoma?

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**Abstract:** Primary thymectomy is the standard treatment for mediastinal masses including thymoma, and continues to play an integral role in the acute and long-term treatment of myasthenia gravis. The traditional surgical approach for removal of the thymus gland was through a median sternotomy. It is argued that this allows for a more complete and radical thymectomy in myasthenia gravis and ensures resections of thymic masses without potential capsular compromise. Complete resection is important as numerous studies have shown that complete removal of all thymic tissue is associated with higher remission in myasthenia Gravis. It is well documented that complete surgical resection of thymomas is the most important long-term prognostic indicator in thymic malignancies. Importantly, violation of proper oncologic surgical technique that results in thymic capsular transgression in a thymoma should be

considered a “never” surgical event, as it dramatically may effect the long term disease free and survival of the patient. Until recently the concern for incomplete or compromised surgical excision has limited the acceptance of minimally invasive thymic resection, especially with regard to thymic masses. With refined minimally invasive techniques, and a rapidly growing world-wide experience in minimally invasive thymectomy (MIT) for non-thymomatous MG, MIT may arguably be performed with the same radicality and oncologic safety as an open thymectomy for TET. Recent literature now supports the ability of highly experienced surgeons and groups to safely resect thymic masses in regards to early operative margins and safety, with long term disease free survival rates awaiting maturation. As with any surgical procedure, experience and judgment and learning curve are important to patient safety, and this may be magnified in a disease such as TET, in which limited centers and surgeons have a large consistent experience. The “learning curve” of both experienced and less experienced surgeons is highly variable, but it is safe to say that some experience in minimally invasive thymectomy in addition to open thymectomy should be a prerequisite for a safe approach to TET’s. Approaches to help assure safe dissemination of this valuable patient care advance will be explored.

**Keywords:** Thymoma; minimally invasive thymectomy; no-touch technique; maximal thymectomy

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