Preface

Benigno lectori salutem

The idea of this special *Journal of Thoracic Disease* (*JTD*) issue was born at the European Society of Thoracic Surgery (ESTS) School in Kazan, Russian Federation in early 2016 and was completed at a roundtable discussion in the Hemicycle of Council of Europe, Strasbourg, France on the terror-related professional tasks of thoracic surgeons in November 2017. The array and scope of the questions to discuss were served on a silver plate by Mother Contemporary History. Our age of the war on terror or indiscriminate and seemingly random attacks on non-belligerents is a call for trauma awareness among all surgeons. Our professional, social and moral responsibilities are challenged and obligations of the global thoracic surgical society dictate the need to reply this dramatic question: mass casualty situation: are we ready?

A short review of any European national or international thoracic surgery conference program proves that chest trauma is on the periphery of our scientific and clinical interest. There has been a growing interest for chest wall stabilization during the recent years. Emergency surgery—a mutatis mutandis mutation of emergency medicine—is still in its cradle, and it is unclear, if and when it will grow up. Hirshberg and Mattox's Top Knife, the Koh-i-Noor of the all-round trauma/emergency surgery handbooks was born 15 years ago. Postmodern surgery, in general, is oncology driven, burning in the fever of minimal invasivity and the technology dependency is increasing day by day. Thoracic surgery is no exception either.

It is our responsibility to find Ariadne's thread which leads out of the maze, even to benefit from the situation. What if chest trauma is looked at not as a problem, but an important element of the solution? Chest trauma and its sequelae open new fields to cultivate for the next generation of thoracic surgeons. The recent rapid workload and profile change of our sister specialty, cardiac surgery should ring a warning bell for us, thoracic surgeons. Adjusting our attitude towards chest trauma offers not a few relative observations. The need for a multidisciplinary approach in thoracic trauma is no less important as we see and practice in the past decades in oncology.

The thoracic surgical skill set is mobilized in surgical pleural space control (bleeding or pneumothorax) combined with maintaining parenchymal oxygen/CO_2 transfer—a primarily intensive therapy task.

There is no good thoracic surgery without leadership skills. Thoracic trauma teaches us and we try to learn: the diaphragm is not a border but a connecting structure between two boxes.

Chest trauma care is a mirror of our surgical pedagogy. Do we teach our trainees how to care the patient not only in the oncological field, how to optimize resources when the A&E is overflowed? These sort of questions are driving the surgeon to a wall in our age and culture where the individual always prevails the group and being a minority equals non-negotiable positive discrimination. We are surrounded by Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) and other saliva triggering methodologies, and video technologies are all around. We should not wait long for the publication of the first robotic surgery for chest trauma—as it would not exist a thing such as the diamond 15 minutes or golden hour.

All the expensive gifts of minimal invasivity are around us looking for space and chance of application. The sad fact is, that decisions to put a simple chest drain in the thorax is a problem in many general hospitals all around Europe. Moreover, the emergency thoracotomy performed by a general surgeons is on a list of extincted surgical procedures. One of the reasons for this is an increasing and understandable fear from malpractice.

Is there an escape route from that catch of 22? Defining clearly our responsibilities and limits of capacities offer a solution. We definitely need allies: trauma surgeons, intensive therapists and hopefully emergency surgeons for the future. What we, general thoracic surgeons have to teach is basic and safe techniques of drainage and thoracotomy and bleeding control.

Yes, we as thoracic surgeons have a responsibility in mobilizing our special knowledge, experience when mass casualty situation calls us. Research and publication, knowledge transfer and experience sharing are the keywords.

The articles in this special issue cover a great numbers of open questions in chest trauma: the main task of a constructive cooperation with general surgeons, the promotion of an emergency surgery, the implementation and further development of damage control thoracic surgery.

The thoracic surgeon should be ready to switch for damage control chest surgery when needed and restart lung standard function when the situation allows. The guest editors offer the present issue with the hope that the following pages will provide sufficient mental and spiritual ammunition for both function modes, which are not exclusive, not competing, but mutually completing each other.

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