Editorial

Surgical approach for substernal goiter

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Approximately 8% of thyroid tumors may present with mediastinal lesions (1). Aberrant mediastinal goiter can be resected with video-assisted thoracoscopic surgery (VATS), but some substernal goiters require surgical manipulation in both the cervical and thoracic regions (2). In patients with ectopic goiter, it is often controversial whether there is fibrous continuity when the primary tumor and mediastinal lesion appear separated on imaging examination (3). However, in the report by Kwak *et al.*, a discontinuous mediastinal nodule was pathologically diagnosed as originating from lung cancer, which was a rare case (4). Conversely, it has been reported that metastasis of differentiated thyroid carcinoma is detected at a certain rate in the superior mediastinal lymph node dissection during lung cancer surgery (5), and detailed pathological examination is important.

As a surgical approach, several reports recommend cervical collar incision (6,7). Hajhosseini *et al.* demonstrated the need to add a partial median sternotomy for an adequate dissection procedure (8). de Perrot *et al.* reported that median sternotomy is necessary after thyroid surgery and in invasive malignancies (9). On the one hand, VATS approach is less invasive and may contribute to the patients' postoperative recovery. In the reported case as well, appropriate treatment for lung cancer was performed after surgery. Insufflation of CO_2 to create a positive intrathoracic pressure is often performed during thoracoscopic surgery (10). Patients undergoing neck collar incisions and those with weak connective tissue should be carefully considered as they may cause additional discomfort when subcutaneous emphysema develops.

As clinicians, we occasionally experience cases with complex clinical courses. In order to find a better treatment, it is important to collaborate closely with multiple clinical departments, as in the reported case.

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