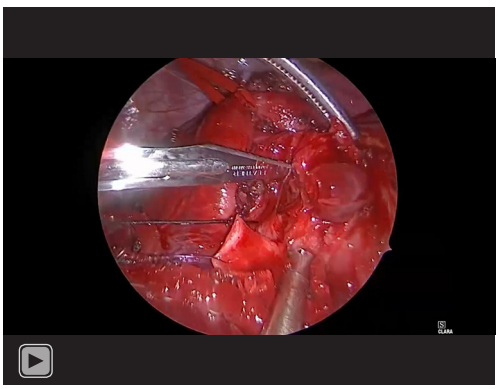
Supplementary

Appendix

The surgery was performed using a two-window method between the anterior fifth intercostal space and the posterior sixth intercostal space (Video S1). The left upper lobe and superior segment (S6) was divided by surgical stapler. The pulmonary artery (A6) and pulmonary vein (V6) were dissected and ligated. A6 and B6 were exposed and dissected distally. After resection of the S6 segment, an incision was made in the B6 bronchus, toward the proximal bronchus, to confirm the base of the tumor. The upper left lobe bronchial root was resected while ensuring a margin from the tumor.

For the bronchoplasty, the anterior wall excision section was sutured with three needle lumen ligatures with 5-0 PDS, and the basal segment branch was sutured with external ligature to reach the membranous section. The defect was sewn by suturing a central longitudinal incision with two needles using 4-0 PDS. The B6 bronchial wall was trimmed to create a flap, and bronchoplasty was performed with 4-0 PDS continuous running sutures to fill the defect. After bronchoplasty, the fifth intercostal muscle valve was wrapped around the flap.



Video S1 Video-assisted flap bronchoplasty for central type typical carcinoid

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