

## Reply to the Letter to the Editor

## Reply to Schier

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We apologise for not having cited the article by Schier et al. [1] in our publication [2]. We regret this error which happened owing to the fact that Dr Haecker did the literature search for our article before publication of the above mentioned paper [1]. We are sorry for this. However, we obtained written permission by Dr Bahr to use his CT-scans showing the vacuum bell applied in a patient suffering from pectus excavatum. We stated in the legend to these figures that these pictures were provided by Dr Bahr (p. 558). To the best of our knowledge, Dr Bahr was also noted at the homepage of Mr Klobe ([www.trichterbrust.de](http://www.trichterbrust.de)) to be the author of these pictures and Dr Bahr declared again that he was the owner of these pictures. We regret that Professor Schier was not informed that his co-author Mr Klobe read our manuscript before submission. We offered the co-authorship of our article to Mr Klobe but he refused to be cited as a co-author in any medical paper due to the fact that he is a technical engineer. However, we mentioned his name (p. 559) and his homepage in our article [2]<sup>1</sup> where interested readers can obtain further information regarding his construct. We stated in our article that Dr Bahr and Professor Schier did the initial tests to investigate the use of vacuum chest wall lifter children suffering from pectus excavatum (p. 558). It was the aim of our study to evaluate our first experience using the vacuum bell use in our setting. We did not state that we were the first to use this old method as we are aware that this treatment modality has been described several decades ago, and we mentioned this fact in our article. This fact was also described at the homepage of Mr Klobe. Finally, we do not fully understand why Professor Schier states in his letter: 'We do not want this to continue...' as our article was published with the knowledge of both of his co-authors.

## References

- [1] Schier F, Bahr M, Klobe E. The vacuum chest wall lifter: an innovative, nonsurgical addition to the management of pectus excavatum. *J Pediatr Surg* 2005;40:496–500.
- [2] Haecker FM, Mayr J. The vacuum bell for treatment of pectus excavatum: an alternative to surgical correction? *Eur J Cardiothorac Surg* 2006;29(4): 557–61.

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<sup>1</sup> [www.trichterbrust.de](http://www.trichterbrust.de).

## Letter to the Editor

Is taking preoperative high-dose steroid necessary?<sup>☆</sup>

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We read the article of Sekine and associates [1] titled 'Does perioperative high-dose prednisolone have clinical benefits for generalized myasthenia gravis?' with great interest.

Thymectomy should be performed in hospitals that have extensive experience not only with the surgery but also with preoperative and postoperative management of myasthenia gravis. Recently, perioperative high-dose prednisone has been used and clinical benefits were provided [2,3]. The reason why we do not use preoperative steroid is because continuous use of steroid is not desirable for the fear of poor wound healing and the occurrence of postoperative infection.

Between 1987 and 2004, a total of 174 patients with generalized myasthenia gravis were experienced at our hospital. One hundred sixty-five patients were administered anticholinesterase inhibitors that improved the symptoms, but 9 patients (5.1%) were myasthenia gravis preoperatively and were hospitalized for the administration of steroid therapy, next all patients were subjected to extended thymectomy. Transsternal extended thymectomy via median sternotomy was performed under general anesthesia by a few skilled surgeons in our hospital. As a rule, patients were extubated at the end of the procedure. On postoperative day 1, the patients were given their regular dose of pyridostigmine while being careful in a cholinergic crisis. About 4 weeks after surgery, steroid therapy was performed by administering 1.5–2 mg/kg (max 100 mg/body), a regimen which gradually was changed to every other day medication and finally a gradual reduction of dosage. Postoperative respiratory insufficiency was noted when a patient underwent mechanical ventilation for more than 24 h during the first 7 days after surgery. Eight patients (4.6%) experienced postthymectomy myasthenic crisis, underwent mechanical ventilation, and received high-dose steroid therapy immediately. There were no steroid related complications such as sternal dehiscence, wound dehiscence, and wound suppuration.

Preoperative preparation should optimize the patient's strength and especially respiratory function, but prednisone should be avoided if possible because prednisone increases the risk of side effects. Comparing the authors' report with our result, no difference in the incidence of