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LETTER TO THE EDITOR

Letter to the Editor concerning "Can standard anterior Smith–Robinson supramanubrial approach be utilized for approach down to T2 or T3?" by Singhatanadgige W, Zebala LP, Luksanapruksa P, Riew KD [Eur Spine J (2017) 26:2357–2362]

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Dear Editor,

We came across and read with great interest the article entitled "Can standard anterior Smith–Robinson supramanubrial approach be utilized for approach down to T2 or T3?" published in the *European Spine Journal* [Singhatanadgige W, Zebala LP, Luksanapruksa P, Daniel Riew K (2017) Can standard anterior Smith–Robinson supramanubrial approach be utilized for approach down to T2 or T3? Eur Spine J; 26:2357–2362].

We commend the authors for establishing this novel technique by which one can decide the approach to the lower cervical and upper thoracic spine. However, we would like to raise a few pertinent points, where we highlight a few limitations in the study.

First of all, regarding the technique, the authors mention the usage of simple lateral view of cervical spine and drawing a straight line from the proposed skin incision to the lowest instrument level.

However, a simple lateral view often does not delineate all seven cervical vertebrae and is often insufficient to visualize the cervico-thoracic junction. A swimmer's view is often needed for the latter and that too is not sufficient in every case [Rethnam U, Yesupalan RS, Bastawrous SS (2008) The Swimmer's view: does it really show what it is supposed to show? A retrospective study. BMC Med Imaging; 8:2]. Therefore, visualization further down to the level of the first-to-third thoracic vertebrae is very unlikely in majority of cases, unless the patient has a long neck. In a short-statured patient with a short neck, we believe that this methodology might not work. Therefore, how the authors were able to base the study solely on a simple lateral view requires some explanation.

Second, in cases of trauma, where the vertebral bodies could be deformed or collapsed, drawing a straight line as suggested in the article could be a difficult proposition.

Third, the authors themselves agree that anterior approach to visualize cervico-thoracic junction is tedious, limited, and technically demanding. In addition, we believe that intraoperatively, visualizing the upper dorsal region under the C-arm with patient supine, itself is very difficult and often impossible. Therefore, one can never be 100% sure about the level that he is working at, during the surgery. Therefore, the feasibility of anterior approach for levels between T1 and T3 vertebrae is not apt in all the cases and will require a surgeon of highest skills. This has a very high and steep learning curve for sure.

We would again like to point that the idea is a novel one, but for a wide implementation in our day-to-day practice, some loopholes need to be rectified.

Compliance with ethical standards

Conflict of interest The authors declare that they have no competing interests.

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