



Letter regarding: Clinical and pathological characteristics of spontaneous pneumothorax in women: a 25-year single-institutional experience [2018;66,9:516–522]

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I have read with interest the article by Tomohito S and associates [1] and congratulate them on the analysis of spontaneous pneumothorax in women. Catamenial pneumothorax (CP) is a reality to be aware of, accounting almost 30% of women pneumothoraces. Previously, my colleagues and I reported the multidisciplinary management of (CP) as one of the possible expression of thoracic endometriosis syndrome (TES) [2]. We were able to evaluate and surgically treat 19 women for CP in TES as the first manifestation of pelvic endometriosis. Pelvic endometriosis was diagnosed on the basis of clinical findings and/or results of pelvic exploration by laparoscopy, performed in the presence of relevant symptoms in 12 out of 19 patients.

I understand from the Authors, that their surgical approach was based on the surgeon decision and it was not standardized. The initial approach to CP must be through videothoracoscopy [3] and, considering the high incidence of pelvic endometriosis in women with TES, it could be advisable to offer them a gynecological consult for indication of adjunctive workout and eventual laparoscopic surgery. In our cohort, pelvic endometriosis was diagnosed in all patients undergoing laparoscopy. The majority of these patients had moderate–severe disease (83.3% at stage III–IV) and were symptomatic. Although laparoscopy is recommended to confirm the presence of endometrial lesions, we have chosen to avoid the procedure in the absence of relevant symptoms considering the excluded patients, as “potentially affected”. Both surgical technique can be performed in a simultaneous manner, though reducing patient’s hospitalization.

It is important to resect all the intrathoracic evidence of endometriosis such as endometrial implant, diaphragmatic holes, and pleural brown lesions. Blebs and/or bullae should be excised too. In our series, pathology of the specimens found one endometrial implant in a bulla not visible at surgery. Pleurodesis has an important role in pneumothorax recurrence prevention, we performed diaphragmatic talc poudrage in all our patients and, where indicated, apical pleurectomy and pleural abrasion were carried on. Pleurodesis efficacy was confirmed, in our experience, by the long follow-up without relapse, including those patients who still complained postoperative monthly thoracic pain, in the absence of pneumothorax recurrence. The association of surgery and medical treatment is considered the standard of care for CP. GnRH-agonist is effective after surgery, in contrast to estrogen–progesterone therapy that cannot prevent pneumothorax recurrence. Our recurrence of pneumothorax, which occurred in five patients, was strongly correlated to estrogen–progesterone treatment. After recurrence, patients received GnRH-agonist therapy. Patients receive hormone therapy until menopause, unless pregnancy attempts, and they are periodically checked both for gynecologic and/or thoracic symptoms.

The strong association between CP, TES and pelvic endometriosis emphasizes the need for optimizing a multidisciplinary approach to treatment by thoracic surgeons and gynecologists in fertile women affected by pneumothorax.

Compliance with ethical standards

Conflict of interest Paola Ciriaco has no conflict of interests.

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