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EDITORIAL COMMENT

Re: Radical nephrectomy and inferior vena caval thrombectomy: outcomes in a lower volume practice

The authors are to be congratulated on their excellent outcomes regarding a challenging surgical problem. There are several points that deserve emphasis. First, the correlation with surgical volume and better outcomes holds true in high volume operations where an individual surgeon may have performed hundreds or thousands of a particular procedure. No one individual has that depth of experience with vena caval thrombi, even at academic centers.

In this report, the value of teamwork is correctly emphasized. Vascular and transplant surgeons contribute valuable expertise and the collective skill and experience of the entire surgical team is important. Like these authors, I also use a chevron subcostal incision on all these cases. It provides a versatile exposure and facilitates going on bypass or rolling the liver (Langenbeck maneuver). I have not personally utilized renal artery embolization which has at least a theoretical risk of necrosis and pulmonary embolization of the distal thrombus. The anesthesiologists at my institution frequently use transesophageal ultrasound and we find it quite useful to monitor removal of the thrombus.

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