

Are the late results of thymectomy satisfactory in the treatment of myasthenia gravis?

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It is demonstrated that thymectomy is more effective than conservative treatment for myasthenia gravis (MG) regarding outcome, clinical improvement and remission rates in long-term follow-up [1,2]. The literature draw attention to patients with non-thymomatous MG obtaining significantly higher rates of complete stable remission than the patients with thymomatous MG [3-5]. The additional prognostic factors were stated as steroid therapy, age of onset, short duration of the disease and finally positive acetylcholine receptor antibodies [1,4-6].

The results of a recent survey of current surgical practice in thymic disease amongst EACTS members showed that, 80.8 % of the surgeons perform thymectomy for both MG and thymic cancer, 78.4% have a strict cooperation with dedicated neurologist and anesthesiologist during the course of treatment and 55.8% operate thymic hyperplasia with Stage I MG (ocular myasthenia) [7].

Although there is no published information, in most of the clinics that I communicate during my surgical practice there has been a debate between neurologists and thoracic surgeons if surgery should be a part of MG treatment. Unfortunately the resistance of some neurologists to surgery for suitable patients was difficult to understand which might be due to obstacles to establish a multidisciplinary team. Under these circumstances it is gratifying to see the results of comparison of the 1st and 5th year outcomes of thymectomy by Dural et al. in this issue of the Turkish Journal of Clinics and Laboratory. The late results of 27 patients underwent thymectomy are consistent with the literature i.e. no significant difference were found in the late outcomes. They concluded that thymectomy is a safe and reliable method for the treatment of MG.

Currently extended transsternal thymectomy remains as the gold standard tool to achieve complete remission rates in MG [1,3-6]. Late results demonstrated that complete remission rates were significantly better in extended transsternal thymectomies compared to basic transsternal thymectomies [8]. Recent studies show that minimally invasive surgery was found to be superior in terms of improvement in MG -associated symptoms. Additionally, the hospital stay was shorter, and the patients felt less disturbed by direct effects of the operation. Therefore, minimally invasive thymectomy can also be a treatment of choice for patients undergoing surgery for MG [9,10]. Although the evidence is low, whatever technique is used the main stay is to leave less thymic tissue behind for better long term results [6].

As a take home message after evaluating those results, extended thymectomy should be recommended in patients with early onset, generalized MG and positive acetylcholine receptor antibodies, and associated thymoma.

References

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