# LETTERS TO THE EDITOR

## Isolated primary chylopericardium

*To the Editor:*

We read with interest the article by Furrer and associates,[1] "Isolated Primary Chylopericardium: Treatment by Thoracoscopic Thoracic Duct Ligation and Pericardial Fenestration." We congratulate them for this first case of isolated primary chylopericardium managed by video-assisted thoracoscopy. However, we think the authors should clarify certain points.

Once the diagnosis of chylothorax has been established, chest tube insertion and a medium-chain triglyceride diet are usually used for 2 weeks. If leakage persists at this time, pleuroperitoneal shunting or thoracotomy for ligation of the thoracic duct is suggested. However, no such approach to isolated primary chylopericardium has been described in the literature. As pointed out in the latest review by Akamatsu and associates,[2] 10 of 79 patients in the literature received conservative treatment, six (60%) of whom had reaccumulation of chylous fluid. Did the authors try any conservative treatment, such as pericardial tube drainage and a medium-chain triglyceride diet, for their patient?

On the other hand, when conservative therapy is ineffective, surgical therapy is the only means of treating the patient and avoiding later progression of cardiac tamponade or constrictive pericarditis.[3] If conservative management was not attempted in the patient, why did the authors wait to operate until the cardiac tamponade had developed?

We had a patient with isolated primary chylopericardium who was unresponsive to conservative treatment with pericardial tube drainage and a medium-chain triglyceride diet. We performed an operation, and 3 hours before the operation we infused 250 ml of olive oil through a nasogastric tube to fill the duct with milky chyle. This allowed us to recognize the duct throughout the course of the operation. Did the authors infuse olive oil to make the duct readily recognized?

Another point is the approach to the thorax. Whereas Ross[4] and others suggested that the most favorable site for ligation of the thoracic duct in the mediastinum is on the right side, Akamatsu and his coworkers[2] suggested that left thoracotomy is a better approach than right thoracotomy. Thus there is no agreement on the best operative site in the literature. We performed a left thoracotomy with no problem. We would like to know why the authors chose the right-sided approach and what their opinion is about this subject?

What was the reason for the loculated residual effusion 1 month after the operation? Some authors believe that a larger pericardial window can be created easily through a left thoracotomy.[2] Could that be the reason for the postoperative pericardial effusion at 1 month, since a right-sided VATS had been performed in this patient?

In the article, "mass ligature" had been recommended as the operative procedure. However, instead of mass ligature, ligation and resection of the thoracic duct is now suggested. Finally, long-term follow-up is suggested,[5] but we think that the follow-up reported for this patient is not long enough. In our case, 6 months' follow-up showed no accumulation of pericardial fluid.

We are interested in reading the authors' comments on these subjects.

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*Reply to the Editor:*

Yüksel and associates have addressed some interesting points concerning the treatment of isolated primary chylopericardium. Although percutaneous pericardial drainage combined with a medium-chain triglyceride diet is recommended as the initial approach,[1] we did not follow this conservative strategy in our patient because of the rapid recurrence of pericardial fluid accumulation with development of cardiac tamponade within 14 days after echocardiographically guided pericardiocentesis. The patient was then referred to our surgical department, and pericardial fenestration with ligation of the lymphatic duct was chosen as a straightforward procedure. Pericardial evacuation was strongly indicated in any case, and repeated pericardiocentesis and dietary treatment were not attempted because of the high probability of recurrence[2] in the case of such rapid development of pericardial effusion. We believe that the minimally invasive approach as described in our brief report[3] is simple, efficient, and cost effective. Conservative attempts should be restricted to children