Letters to the Editor

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- Include no more than 500 words of text, three authors, and five references
- Type with double-spacing
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Acute postoperative lobar torsion associated with pulmonary arterial rupture

To the Editor:

We read with interest the review "Lobar Torsion After Pulmonary Resection: Presentation and Outcome."¹ Lobar torsion is indeed a rare complication of elective lobectomy. Most cases of lobar torsion manifest in a delayed fashion, often from pulmonary venous congestion, when the twisted lobes are often considered nonviable.^{1,2}

In contrast to these studies, we report a case of pulmonary arterial rupture associated with acute postoperative lobar torsion. A 62-year-old man underwent elective left upper lobectomy for squamous cell carcinoma (pT2 N0) with routine division of the inferior pulmonary ligament. Surgery was unremarkable, and the patient was extubated in the operating room. On transfer to the recovery room, however, a dramatic increase in bleeding of more than 2 L from the underwater seal chest drains was noted, accompanied by systemic hypotension. The patient was reanesthetized, intubated, and transferred for emergency reopening of the thoracotomy. During thoracotomy, which revealed a significant volume of blood in the pleural cavity, the patient sustained a ventricular fibrillatory cardiac arrest. After the pericardium was opened, intracardiac adrenaline was administered, and internal cardiac massage and defibrillation were performed. Lobar torsion was diagnosed, with the diaphragmatic surface of the lower lobe facing in an anterosuperior orientation. A laceration at the junction of the main pulmonary artery with the apical branch of the lower lobe was detected, in keeping with the line of torsion. There had been no dissection around this branch at the initial operation. The laceration was repaired with 4-0 Prolene suture (Ethicon, Edinburgh, United Kingdom), and subsequent recovery was uneventful.

It had been our standard practice to divide the inferior pulmonary ligament during upper lobectomy. However, it is possi-

ble that this is more likely to allow torsion, in a similar manner to an unfixed middle lobe after right upper lobectomy.³ We therefore changed practice after this event. We no longer divide the inferior pulmonary ligament during upper lobectomy, because, in theory, this could reduce the risk of torsion.² This would be difficult to prove, however, because of the rare occurrence of this complication. It is, however, interesting that there has been no increase in the incidence of problems as a result of a residual space in the apex of the pleural cavity, since this decision not to divide the inferior pulmonary ligament was taken. We are interested to hear the comments of other surgeons who may have seen cases of this previously unreported presentation of lobar torsion and would appreciate their views on division of the inferior pulmonary ligament.

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3. Wong PS, Goldstraw P. Pulmonary torsion: a questionnaire survey and a survey of the literature. *Ann Thorac Surg*. 1992;54:286-8. doi:10.1016/S0022-5223(03)00119-3

Free right atrial patches for septal defect closure

To the Editor:

The article "Atrial Septum Around the Fossa Ovalis: An Ideal Patch for the Ventricular Septal Defect" by Yamagishi and colleagues¹ interested me for many reasons. Yamagishi and colleagues¹ are to be congratulated on their innovative tech-