association between the Symmetry and proximal graft failure. My concern is in the wider area of dissemination and adoption of new technologies. Without statements on data limitations, publication of biased noncomparative data on any new technology is potentially alarmist (or overoptimistic), may prevent proper evaluation and development, and may unnecessarily hinder (or accelerate) uptake of new technologies, some of which could be potentially beneficial (or harmful). Authors of reports on new technologies should list limitations and highlight any confounding factors or alternative explanations for adverse events (or benefits); otherwise readers could be inadvertently misinformed.

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References

1. Hornik L, Tenderich G, Minami K, et al. First experience with the St Jude Medical, Inc, Symmetry Bypass System (Aortic Connector System). *J Thorac Cardiovasc Surg.* 2003; 125:414-7.
2. Reuthebuch O, Lachat M, Kadner A, Turina M. Early bypass occlusion in patients with the St Jude Medical Symmetry connector. *J Thorac Cardiovasc Surg.* 2003;125:443-4.
3. FitzGibbon GM, Burton JR, Leach AJ. Coronary bypass graft fate: angiographic grading of 1400 consecutive grafts early after operation and of 1132 after one year. *Circulation.* 1978;57:1070-4.
doi:10.1016/S0022-5223(03)01051-1

Reply to the Editor:

I thank Mr Anyanwu for his interesting remarks.

I agree with the statement of Mr Anyanwu concerning the use of the internal thoracic arteries in coronary artery bypass grafting. I used to follow the same strategy and prefer extended utilization of the left internal thoracic artery as a graft especially, for the left anterior descending (LAD) and/or diagonal branches. We accept it as graft source irrespective of patient age, so that in about 92% to 95% of the patients the left internal thoracic artery is placed in the LAD area, although the average patient age is around 72 years old. I decided intentionally to make an exception to this strategy as I wanted to gain intensive experience with the new technology in creating the proximal vein graft anastomosis within a short period of time, so that mostly no internal

thoracic arteries were used in the mentioned patient group unless the vein quality was inadequate.

Although in this series the first use of the anastomotic device took place on April 30, 2001, and the last one on October 22, 2001, of these 45 reported patients, 35 were operated on in the relatively short period of time from June 1 to July 5, 2001.

I agree that the calcified ascending aorta implies the utilization of the pedicled internal thoracic arteries. However, I often place many grafts in multimorbid octogenarians with more or less calcified ascending aortae, and I am forced to at least partial use of vein grafts. I try then to find the most suitable site for the proximal anastomosis, regardless whether the given anastomosis is hand-sewn in the conventional way or performed by use of any anastomotic device. I have never faced results like these until now. In very heavily calcified ascending aortae, both techniques are expected to fail; if at all possible the aorta should be replaced.

For the same reason of gaining experience with off-pump techniques within this period of time, accepted coronary patients were primarily declared for off-pump procedure without any preselection (ie, regardless of coronary morphology and other relevant factors).

I used to make the final decision to proceed or not with the off-pump technique at the very beginning of the surgery, making it dependent on the feasibility of this technique, so that many patients were switched to on-pump without making any effort to follow the off-pump strategy. I converted to on-pump quite liberally for 2 reasons. First, I am generally not convinced of the superiority of the off-pump techniques; second, I often face an extremely bad coronary morphology and/or bad ejection fraction. I mean the borderline cases in whom the feasibility of coronary artery bypass grafting is generally problematic. With those patients, we try to proceed with the conventional bypass surgery before we are forced to use any form of an end-stage therapy (ie, heart transplantation, implantation of an assist device for recovery, for bridging, or as definite surgery). Our heart center is a leader in utilizing mechanical circulatory support devices; we successfully follow this strategy in patients with end-stage coronary artery disease for a long time.

My article is a case report and not a randomized study; as such, you will find no comparison with any statistical significance. However, the causality between the utilized technology for creation of the proximals and the reported complication is in my opinion quite possible as these complications are an exceptional "on the row" phenomenon in my practice. I used to perform about 350 to 450 isolated coronary artery bypass grafting procedures each year; the operative capacity of the entire heart center is about 5000 cardiac procedures including approximately 3500 isolated coronary artery bypass grafting procedures yearly. My colleagues and I have never faced a similar experience. These were the first graft occlusions or stenoses that I had to deal with in many years.

I would like to use this opportunity to report an additional case of severe stenosis of the proximal vein graft anastomosis created with ACS. A 65-year-old man with 1 sequential vein graft to LAD and diagonal branch placed in off-pump technique using the ACS developed de novo angina pectoris 6 months after surgery. Angiography revealed a severe stenosis of the proximal anastomosis. Very impressive was the retrograde filling of the graft until the stenosed proximal anastomosis. The patient underwent successful redo surgery; I could not find any explanation for the event this time, either. However, I do not claim to deliver any evidence for or against the utilization of the device. I have highlighted in my article that the role of the device in the genesis of the reported complications has to be cleared.

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Pattern of lymphatic spread and prognosis in pN1 non-small cell lung cancer: What does it stand for?

To the Editor:

We read with great interest the report from Marra and colleagues¹ recently published in the *Journal*, and we warmly congratulate them on their excellent, accurate, and exhaustive analysis and report. They have confirmed that within the pathologic N1

(pN1) group of tumors involvement at the intralobar level is substantially better prognostically than that at the hilar level (as well as single versus multiple nodes or stations).

Because this strongly and comprehensively supports the idea that it is correct to stratify (classify) the pN1 cases according to the level (intralobar best, hilar worst) in addition to the number of involved lymph nodes (one better, more than one worse) we amicably invite Marra and colleagues to clarify their position regarding the possible use of such important information, especially regarding the opportunities to actually “stratify for optimization” in terms of adjuvant and neoadjuvant treatment. In fact, the discussion of their experience is mainly focused on the evaluation of such evidence in comparison to others’ similar work. Regarding adjuvant treatment, we have developed a timely consolidated experience in the adoption of postoperative radiotherapy in completely resected non-small cell lung cancers, even in the early stage.^{2,3} Moreover we have directly discussed the Post Operative Radiotherapy Trialists Group conclusions⁴ and strongly support the evidence that modern radiotherapy, accurately planned and administered, can give good results with acceptable side effects in this class of tumors.

From the report of Marra and colleagues,¹ we have taken the idea that because for the best prognostic class pN1 cases any therapeutic effort aimed at the local control could have significance, modern radiotherapy could certainly find its place, especially at the investigational level. For the worst prognostic class pN1 cases, we agree with Marra and colleagues¹ that an attempt at systemic (rather than local) control is justified. In the setting of neoadjuvant treatment, we see the point of view of the Marra and colleagues¹ when they note that it is “promising.” The core fact in managing patients with N1 disease in the clinical setting is that it is truly difficult to obtain a substantially correct diagnosis of true clinical N1 status. In their very reported experience, in fact, Marra and colleagues¹ noted a limited (24.5%) pathologic confirmation rate of clinical N1 assessment. Moreover, when a suspicion of N1 involvement is present at the clinical staging, this is rarely histologically or cytologically assessable; thus an induction treatment planned on the basis of the clin-

ical N1 status alone may still be considered hazardous. In fact, the best that is currently done in the ongoing phase III induction trials for early stage non-small cell lung cancers is to exclude, when N1 status is suspected, the involvement of N2 stations by cervical mediastinoscopy, leaving substantially uncovered the erroneously clinically upstaged to N1 cases (true N0s). We would be very grateful if Marra and colleagues could disclose and describe their point of view regarding these issues.

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References

1. Marra A, Hillejan L, Zaboura G, Fujimoto T, Greschuchna D, Stamatis G. Pathologic N1 non-small cell lung cancer: correlation between pattern of lymphatic spread and prognosis. *J Thorac Cardiovasc Surg*. 2003;125:543-53.
2. Granone P, Trodella L, Margaritora S, Cesario A, Corbo GM, Mantini G, et al. Radiotherapy versus follow-up in the treatment of pathological stage Ia and Ib non-small cell lung cancer. Early stopped analysis of a randomized controlled study. *Eur J Cardiothorac Surg*. 2000;18:418-24.
3. Trodella L, Granone P, Valente S, Valentini V, Balducci M, Mantini G, et al. Adjuvant radiotherapy in non-small cell lung cancer with pathological stage I: definitive results of a phase III randomized trial. *Radiother Oncol*. 2002;62:11-9.
4. Granone P, Keller S, Trodella L, Cesario A, Margaritora S, Porziella V, et al. Postoperative radiotherapy in completely resected, early-stage, non-small-cell lung cancer: reflections and future directions. *Lancet Oncol*. 2002;3:589-91.
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Reply to the Editor:

We are glad to respond to the questions of Margaritora and colleagues, as they come from a thoracic surgical group with an established experience in the multimodality treatment of lung cancer.

The results of our study show that pN1 non-small cell lung cancer (NSCLC) could not be considered an “early stage” disease, because as many as 45% of patients at the time of diagnosis and treatment had occult disease beyond the boundaries of the lobe of origin, if we consider that even a locore-

gional recurrence develops outside the margins of “radical” surgical resection.

Another finding is that N1 NSCLC behaves heterogeneously, with two extremes: a population of patients with hilar lymph node metastases prognostically comparable to “limited” N2 disease and, on the other side, a more favorable subgroup of cases with N1 disease by direct infiltration of pulmonary lymph nodes. This difference involves also the pattern of tumor relapse. In fact, we have observed rates of cancer recurrence of 41% at distant sites and of 12% locoregionally for the hilar N1 group and of 24% and 17%, respectively, for the N1 group by direct invasion. It is therefore our opinion that the optimal treatment of all these patients mandates multimodality approaches, which should be appropriately investigated by means of randomized clinical trials.

In the adjuvant setting, in all N1 subgroups the risk of distant metastases overwhelms that of locoregional recurrence. This evidence represents a rationale to use systemic therapy (eg, chemotherapy) after surgical resection, although the role and effectiveness of adjuvant chemotherapy in early stage NSCLC are still controversial.^{1,2} Radiotherapy seems to be less mandatory, because adequate surgery is able to achieve long-term local control in as many as 85% of patients and chemotherapy may also contribute to reduce locoregional failures. Nevertheless, the cited phase III study on patients with N0 NSCLC suggests that modern radiation therapy improves local control with an acceptable toxicity.^{3,4} Further randomized trials are needed to define the role of radiotherapy in N1 NSCLC. Interesting data could be obtained from the forthcoming publication of the results of the International Adjuvant Lung Cancer Trial (EORTC Trial CT0142), which in stages I to IIIA NSCLC compares different adjuvant chemotherapy regimens (cisplatin plus VP16 or cisplatin plus vinca alkaloids) against control, with radiotherapy being optional.

In the neoadjuvant setting, preoperatively scheduled chemotherapy, alone or in combination with radiotherapy, provides survival advantages in locoregionally advanced NSCLC, as shown by many clinical trials.⁵⁻⁷ Phase II studies of patients with early-stage NSCLC treated with induction chemotherapy have had encouraging results, but randomized trials are needed to