1. To understand the real world from which their patients were selected, we need to know how many patients were refused entry into their study.
2. The benefits of combined resection and radiation therapy might be put into better perspective if we could see the survival data and curves on the patients refused entry into the study. All hospital tumor boards certified by the American Cancer Society will have this information.
3. Because early studies by Devalle and coworkers² indicated a late surgical mortality of 11% beyond the usual 30-day perioperative period, it is important to learn whether such events still occurred in the 1990s. Similarly, early reports noted by Ruffie and colleagues³ indicated 10% late suicides after surgery. A statement regarding the occurrence or nonoccurrence of suicidal deaths during long-term follow-up is important in assessing the quality of life and the suffering of the patients.
4. What were the lengths of the hospital stays of the included and the excluded surgical groups? How many days of hospitalization were required in long-term follow-up for the complications of radiation therapy and surgery? These data are important in assessing the patients' quality of life as well as the cost of care.
5. How many of the patients had large recurrent or persistent pleural effusions? Several investigators have suggested a survival advantage for this group relative to those with a soft-tissue mass.
6. It is interesting that 69% of this selected group of surgical patients had such high staging (III and IV). By comparison, Sugarbaker and associates⁴ found 136 of 183 (74%) to have stage I and II disease in a series that had excluded 2 to 3 patients for every patient accepted. Does this difference indicate that Sugarbaker and associates⁴ had a more effective technique to screen out patients with stage III and IV disease for surgical resection? It is disappointing that so few patients with stage I and II disease were found in the study of Rusch and colleagues.¹ Perhaps rigorous intraoperative staging up-grades preoperative stage to the extent that few patients with stage I and II disease remain, even with prompt evaluation after the onset of symptoms. Presumably nonsurgical disease would be falsely staged lower because of the absence of mediastinal sampling, laparoscopy, and so on, making comparison of surgical and nonsurgical groups more difficult.
7. The median survival was stated to be 17 months in this study, but that number excluded the 7 deaths and the 21 patients whose disease could not be completely resected. Obviously, we need to know the median survival of all patients operated on, including perioperative deaths, if we are to provide honest informed consent with surgical referrals.
8. Rigorous statistical assessment of surgical trials becomes even more important in light of a recent consecutive, unselected series of 26 patients with malignant mesothelioma with pleural effusion and treated by medical thoracoscopic talc pleurodesis as the primary modality of care. They had a median survival of 19.4 months and have a mean survival that is now reaching 22.8 months.⁵⁻⁷ Although Rusch⁷ has previously indicated the difficulties of doing randomized controlled studies in this disease, such studies may be necessary to separate theoretic from the real benefits of surgery.

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Early bypass occlusion in patients with the St Jude Medical Symmetry connector

To the Editor:

In recent years, off-pump coronary artery bypass grafting has gained increasing acceptance because of the reduction of possible negative effects of extracorporeal circulation. This technique was shown to be beneficial, especially in elderly patients.¹ However, the manipulation of a possibly diseased ascending aorta in elderly patients might increase the risk for neurologic complications.²

In May 2000, St Jude Medical, Inc (Minneapolis, Minn) introduced an anastomotic device (Symmetry Aortic Connector System) to facilitate the proximal vein-aorta anastomosis without side clamping the aorta. Since June 2001, we have used the Symmetry mechanical anastomotic device preferably in off-pump coronary artery bypass grafting procedures, especially when transesophageal echocardiography revealed a calcified ascending aorta.³ Between June 2001 and April 2002, we have deployed the device in 51 male and 10 female patients (mean age, 68.6 ± 8.6 years). A total of 77 Symmetry connectors were used (1.3 per patient). Loading of the connector was simple, and time for anastomosis was less than 15 seconds. After deployment, the free graft flow was assessed by removing the bulldog clamp from the

vein before the distal anastomoses were performed. In case of uncertainty or bleeding, the Symmetry connector was replaced.

Before closing the chest, we reassessed flow with an additional measurement by using the transit time flow probe (Medi-Stim, Oslo, Norway).

No neurologic deficiencies were observed, and 54 of 61 patients had an uneventful postoperative course. However, in 7 (11.5%) of 61 patients, we encountered device-related complications: in 1 patient occurring intraoperatively, in 2 patients within 5 days after the operation, and in 4 patients within 6 months postoperatively.

Six patients were subjected to repeat coronary angiography: 1 patient had ventricular fibrillation and consequent resuscitation; 5 patients had a recurrence of angina, dyspnea, or both; and 1 patient had loss of flow detected intraoperatively with a new image system (Spy Novadaq, Toronto, Ontario, Canada). This occlusion was due to an aortic plaque that was not properly cut by the Symmetry cutter and therefore closed the new aortic opening like a cover. Repeat angiography in 6 of 7 patients showed an occlusion of the vein graft right at the neo-ostium. Kinking of the graft was never observed as a possible cause of closure. Three patients underwent reoperation within 6 days. In 1 patient the graft was dilated, in 2 patients the graft was stented, and in 1 patient further treatment was not considered necessary because of the small size of anastomosed artery.

On the basis of these observations, we have stopped the routine use of the Symmetry connector and reserve the device for patients who have a severely calcified ascending aorta (grade IV-V), in whom other alternative techniques (vein anastomosis to the internal thoracic artery or to the innominate artery) are not possible.

Although we fully acknowledge the potential benefits of a nontouch vein graft-aorta anastomosis, further investigations and possibly improvements of the connector are necessary to evaluate the potential benefits of this interesting technology.

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Horner syndrome To the Editor:

I compliment Naimer and associates¹ for drawing attention to the important problem of Horner syndrome after manipulation of the subclavian artery in the neonate. As Naimer and associates¹ pointed out in their report, there are remarkably few references to this complication. Although Horner syndrome may seem to be a minor problem to physicians caring for children with complex congenital heart disease, its cosmetic consequences are certainly not viewed lightly by parents of affected children.

Horner syndrome not only has been described after subclavian flap aortoplasty, as in the report by Naimer and associates,¹ but also is seen regularly after a thoracotomy approach to construction of either a modified or classic Blalock shunt. I believe that this is one of the important advantages of approaching construction of a modified Blalock shunt through a median sternotomy. In our 1995 report,² my colleagues and I found no cases of Horner syndrome among 52 patients who had a modified Blalock shunt constructed through a sternotomy approach. We also found a significantly lower probability of shunt failure with the sternotomy approach than with the thoracotomy approach. I believe that the sternotomy approach is technically easier and less likely to result in distortion of the hilar branches because the distal anastomosis is placed more proximally on the branch pulmonary artery. This also facilitates subsequent takedown of the shunt. In contrast to our experience with the sternotomy approach, we found that 2 of 16 patients who

underwent a thoracotomy approach as part of first-stage preparation for a rapid two-stage arterial switch had Horner syndrome develop.²

I am in complete agreement with the conclusion of Naimer and associates¹ that there are probably many unidentified cases of Horner syndrome that occur after manipulation of the neonatal subclavian artery. Careful consideration should be given to choosing surgical techniques and approaches that avoid manipulation of the subclavian artery in the region of the sympathetic pathway.

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Impact of comorbidity on survival after surgical resection in patients with stage I non-small cell lung cancer

To the Editor:

I read with interest the recent article by Battafarano and associates¹ on significantly adverse impact of comorbidity on survival of patients with resected stage I non-small cell lung cancer. Although the vast majority of patients with early stage (I and II) disease are treated with surgery, a small subset of these patients are not candidates for surgery because of preexisting comorbidity. Such patients are treated with radiotherapy alone.²⁻⁹ In this patient population high-dose, standard fraction, or hyperfractionated radiotherapy is capable of achieving median survivals as long as 30 months and 5-year survivals as great as 30%,^{7,8} with values going up to approximately 40 months and 40%, respectively, for T1 N0 cases.⁹

This patient population clearly represents a case of extremely negative selec-