Pulmonary metastatic melanoma

To the Editor:

I read with interest the article by Rebecca and colleagues.¹ I want to commend the authors for their great effort to produce this important article, but I have some comments about it.

The type of extrathoracic metastasis can affect the prognosis, but you did not mention which type of extrathoracic metastasis was present. The number of these extrathoracic metastases also was not mentioned. I think that these extrathoracic metastases, even with their control, are a contraindication for further surgical intervention.

The frequency of the site of these pulmonary metastasis was also not mentioned. From your results there were 23 bilateral thoracotomies: were they done at the same sitting or in sequence? Why did you not perform median sternotomy for bilateral management of these metastasis?

I want also to ask about the side of pulmonary metastasis and its effect for the prognosis.

From the results, you had mentioned that the median follow-up of living patients was 65 months (0.1–524 months).¹ From

that result I can suggest that the least time for follow-up was 0.1 month, which equals only 3 days. That is too little for follow-up. Also, the maximum follow-up was 524 months, which equals 43.6 years. That exceeds the proposed time of the study (from January 1, 1970, to June 1, 2004, which is only about 34.5 years).

My last comment concerns the last word of your article: It reads Figure E3; I think that you meant Figure 1.

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[Response declined]

Reference

1. Rebecca P, Petersen RP, Hanish SI, Haney JC, Miller III CC, Burfeind WR, et al. Improved survival with pulmonary metastasectomy: an analysis of 1720 patients with pulmonary metastatic melanoma. *J Thorac Cardiovasc Surg.* 2007;133:104-10.

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Superior vena cava resection without blood flow interruption

To the Editor:

We agree with Leo and associates¹ that clamping of the superior vena cava (SVC) can cause severe hemodynamic changes with possible serious clinical consequences, particularly when the SVC blood flow was not already gradually reduced by venous wall pathology, usually neoplastic infiltration. For this reason, at the beginning of our clinical experience with SVC resections, we successfully used a temporary intraluminal shunt.²

However, after a few cases, we shifted to the much more simple and accurate technique of performing, as the first procedure after sternotomy (or thoracotomy), ringed polytetrafluoroethylene graft (12–18 mm) interposition between the amputated right atrial appendage tip and the left (occasionally right on thoracotomy cases) brachiocephalic trunk (Figure 1). This procedure does not interrupt blood flow through the SVC (Figure 1, A), and after the blood flow through this conduit is established, SVC clamping (Figure 1, B) and removal (Fig-

Figure 1. In all phases of the procedure, upper body district venous discharge is maintained through one of the brachiocephalic trunks.