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]

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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.

ure 1, C) can be carried out with neither clamping time limits nor significant hemodynamic changes.

We prefer not to reestablish the prosthetic continuity of the right brachiocephalic trunk with the "atrial" SVC stump because the upper body district venous blood sharing between 2 prosthetic conduits might enhance reduced blood velocity in one of them and its possible thrombosis and infection (3/6 cases of double prosthetic conduits SVC reconstruction in our series).

Obviously, in those infrequent cases in which the SVC can still be patch repaired but the lesion is too extended to allow tangential clamping, the polytetrafluoroethylene graft is kept only temporarily³ and then removed after SVC reconstruction is completed.

Moreover, even in those cases in which it seems appropriate to site the distal anastomosis on the SVC, the clamping time can be reduced to half if the conduit is first anastomosed to the right atrial appendage instead of to the proximal SVC stump.

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Reply to the Editor:

We thank Drs Rossella and Nazari for their technical comments on the possibility of reconstructing the superior vena cava (SVC) without the need of crossclamping by connecting one brachiocephalic vein (BCV) to the right atrial appendage. It represents an interesting alternative by avoiding temporary SVC occlusion, but we still prefer SVC crossclamping for 3 reasons.

First, in our experience, SVC reconstruction with the BCV stump is at higher risk of thrombosis. We recently reported our experience with 70 cases of SVC resection from 1998 through 2004.¹ Of the 25 complete prosthetic replacements, 6 thromboses were recorded, and 4 of them (66%) were in patients with BCV reconstruction. Possible explanations are the length of the prosthesis, the limited diameter of the BCV, and the discrepancy between SVC and BCV calibers. At present, our indication for BCV reconstruction is limited to situations in which an alternative is not feasible.

Second, hemodynamic instability occurring at SVC crossclamping is a limited problem as long as anesthetists are aware of methods to overcome it.² It is a frequent event (30%) that can be managed in almost all cases with aggressive resuscitation maneuvers. Intraoperative hypotension by itself should not stop the operation unless corrective maneuvers are unsuccessful (5% of cases). On the other hand, in our experience right atrial appendage clamping can also cause intraoperative patient instability

through the occurrence of supraventricular arrhythmias.

Third, our preference for an SVC prosthesis is the use of bovine pericardium,³ which is a reliable material, even in the context of pulmonary artery reconstruction.⁴ In case of sternotomy or a transnubial approach, such a prosthesis on the left BCV might become occluded by manubrial compression at sternal closure. When a left BCV reconstruction is required, we prefer a ringed polytetrafluoroethylene prosthesis.

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