unfortunate that he has not shared our favorable experience. He attributes this failure to “different environmental factors” between Birmingham, Alabama, and Szczecin, Poland. Although the author may be correct and there indeed may be environmental factors at play, I wonder if other reasons may explain his findings, because we are aware of several different groups in different parts of the country who have used the criteria of 450 mL/d or less with good results.

The author removed the chest tubes on postoperative day (POD) 1 in 15 patients. This is not our experience or our recommendation. As shown in Table 1, no patients had a chest tube removed on POD 1. However, I agree that our article is not clear on this point. We rarely if ever remove a chest tube on POD 1 after a lobectomy or bilobectomy because we believe there is little advantage to doing so. Although there is obvious pain involved with any indwelling tube, and we have written extensively on the advantage of fast-tracking patients and that early tube removal improves ambulation and pulmonary toilet, we have not condoned the removal of tubes on POD 1 after lobectomy. How many of Dr Grodzki's patients who returned for drainage was in this group of 15 patients? Second, and most important, is that Dr Grodzki does not tell us how many of his patients who underwent pleural fluid drainage were actually symptomatic with shortness of breath from their effusion and how many were better once drainage was performed. It has been my experience in the United States that it is common to see residual fluid and postoperative changes in the lung and pleural space after lobectomy, especially after bilobectomy. These are normal postoperative findings and are all too often overtreated by our medical colleagues. We often have to convince physicians not to overtreat these “pleural space abnormalities of air or some fluid” after thoracotomy and to leave the asymptomatic patient alone. Too often the chest roentgenogram is treated as opposed to the patient. Patients often receive antibiotics for “pneumonia” and diuretics or thoracentesis for fluid that never required treatment in the first place. Thus, it would be important to know how many of his patients were symptomatic and even more important to know how many were dramatically better once the fluid was drained. Finally, because most of his patients underwent a single thoracentesis, are we to be-

lieve that 1 tap, which rarely removes all of the fluid, completely resolved a pleural space problem? In our experience it does not.

We appreciate Dr Grodzki's letter, and we agree that the pleural space is a mystery. We look forward to further prospective studies in this regard.

Robert J. Cerfolio, MD
General Thoracic Surgery
University of Alabama at Birmingham

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Removal of left ventricular tumors by a transaortic transvalvular approach with the help of thoracoscopic instruments

To the Editor:

We read with interest the case report from Walkes and colleagues¹ describing their new technique to resect a left ventricular fibroelastoma. Indeed, a left ventricular tumor location can be a real challenge for surgeons when a transmitral approach is performed. We agree with the authors that a safe and more reasonable surgical approach can be used through the aortic valve with the

help of a thoracoscope and thoracoscopic instruments.

However, we want to highlight that this technique has already been published. We² described in 2006 this same surgical approach (Figures 1), which helped us to ensure the mass nature, its resectability, and its single location, since in a few cases multiple tumors can be found operatively but undetected by preoperative echocardiography. In 1997, Espada and colleagues³ also published the use of a thoracoscope through a left atrial approach to visualize and resect a left ventricular fibroelastoma.

We are thankful for this other report, which highlights a safe but unusual procedure to remove left ventricular tumors.

Alexandre Le Guyader, MD

Marc Laskar, MD

Thoracic and Cardiovascular Surgery Department
University of Limoges and Limoges
University Hospital
Limoges, France

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Right atrial papillary fibroelastoma associated with atrial septal defect, persistent superior vena cava, and coronary artery disease

To the Editor:

We read with interest the article by Lauten and coworkers¹ regarding the successful resection of a right atrial papillary fibroelastoma (PF). We have additional surgical experience with this infrequent location of the neoplasm.

A 60-year-old man with a history of arterial hypertension and a transient ischemic attack underwent a transthoracic echocardiogram, which demonstrated a mass inside the right atrium (RA). Further cardiologic evaluation including transesophageal echocardiogram and complete cardiac catheterization and coronary arteriography disclosed a tumor in the RA, fenestrated atrial septal defect (ASD), persistent left superior vena cava (LSVC), and severe coronary artery disease with tight stenosis in the proximal left anterior descending coronary artery (LAD) and middle right coronary artery (RCA). The patient underwent surgery on June 6, 1998. A median sternotomy was performed. Under standard cardiopulmonary bypass, with cannulation of the aorta, both venae cavae, and the LSVC, the aorta was crossclamped. Intermittent cold blood cardioplegia was administered and the three venae cavae were snared. A right atriotomy was performed, a 2 × 1.5-cm gelatinous tumor attached to the muscular endocardium of the RA was completely removed, an ostium secundum type of ASD was closed with an autologous pericardial patch, and a double coronary bypass graft to the LAD and RCA was carried out. The patient had an uncomplicated surgery and recovery and was discharged home 10 days after the operation. Gross and histologic examination of the mass was typical of PF. At present, 9 years 6 months after the operation, the patient remains asymptomatic. A recent transthoracic echocardiogram showed no intracavitary masses, closure of the interatrial septum, and normal left ventricular function.

PF is an endocardial tumor that represents the second or third most common car-

diac neoplasm, accounting for less than 10% of all primary benign heart tumors. It is most frequent in the left side of the heart and generally develops in the heart valves; however, other endocardial heart locations have also been described. Right PF arising from the nontricuspid valve or interatrial septum is extremely uncommon. We only found a few surgically treated patients.¹⁻⁷ To the best of our knowledge, excision of a free-wall PF in association with closure of an ASD and coronary artery bypass grafting has not been previously reported.

Cipriano Abad, MD^a

Pilar De la Rosa, MD^b

Department of Cardiovascular Surgery^a

Department of Pathology^b

Hospital Universitario

de Gran Canaria Dr Negrin

Las Palmas de Gran Canaria, Spain

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The present and the future in aortic stenosis management: Are there factors that might preclude surgery?

To the Editor:

I read with great interest the article by Bertrand Marcheix and associates.¹ I congratu-

late them for this well-designed study, but I also wish to add some brief comments. The aim was to determine the impact of less-invasive techniques for treatment of high-risk patients with aortic valve disease by using a self-expandable aortic bioprosthesis (CoreValve Inc, Paris, France) suitable for percutaneous retrograde delivery. The mean logistic EuroSCORE was 32%. Of 10 patients undergoing successful implants, 2 died within 30 days and a third died later, for an overall 30% hospital mortality. Vascular complications were observed in 5 patients. Mean intensive care unit stay was 4.6 days and hospital stay was 15 days. The authors concluded that the technique is a viable alternative in selected high-risk patients.

With the aim of reducing surgical invasiveness, epidural anesthesia, maintaining an autonomic ventilation, has been suggested,² and the outcomes of 30 consecutive patients who underwent epidural awake aortic valve surgery (47% female, mean age 78.1% ± 8, 20% multivessel coronary disease, mean Logistic-EuroScore 28.3) have been presented at the European Association for Cardio-thoracic Surgery meeting in Geneva. One patient had a redo operation. Associated surgical procedures included coronary artery bypass grafting (17%), ascending aorta replacement (10%), mitral valve surgery (10%), and pulmonary vein isolation to treat atrial fibrillation. Unless emergency, no other exclusion criteria were considered. One patient died, for an operative mortality of 3%, and 2 patients died during the follow-up period (natural death). All other complications occurred rarely (stroke, no cases; bowel ischemia, no cases; prolonged mechanical ventilation, 2 cases; myocardial infarction, 1 case). Median stays in the ward and the intensive care unit were 4.5 days and 1 day, respectively. Seven patients have been transferred to the ward within 3 hours after surgery and 19 patients in 12 hours or less.

The goal of aortic valve stenosis treatment is to achieve a complete regression of symptoms while offering the lowest morbidity and mortality. The main reason that percutaneous interventions are more acceptable to the patients is the simplicity. Unfortunately, interventional cardiologists and cardiac surgeons are going to rethink the management of high-risk aortic stenosis^{1,3,4} without a well-founded clinical program and forgetting the patients' and economic