segment of dilated, abnormal aorta at the time of the first operation in a patient with BAV disease should recognize that he or she has most likely performed—for whatever reason—an incomplete procedure, something E. Stanley Crawford, MD, told us over 20 years ago was the “great surgical sin of omission.”

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COMPUTED TOMOGRAPHY AND ENDOSCOPIC ULTRASOUND IN DETECTION AND CHARACTERIZATION OF MEDIASTINAL MASSES

To the Editor:

We read with great interest the recent paper on bronchogenic cyst by Azeem, Rathwell, and Awad.¹ They

reported the case of a female patient with an intrapericardial bronchogenic cyst compressing the left main coronary artery who had acute severe coronary ischemia. Two weeks post-operatively a magnetic resonance imaging (MRI) study showed another cyst in the subcarinal position not compressing the nearby structures but requiring a second operation.

Bronchogenic cysts account for 6% to 15% of primary mediastinal masses.² These lesions are usually detected incidentally by chest radiography or computed tomography (CT), but in some cases they could present as an emergency, life-threatening situation.³ Symptoms of intrapericardial bronchogenic cysts can vary with the location and size of the mass and with the compression on the heart and vessels. If symptoms such as chest pain, shortness of breath, and arrhythmias are present, it is important to consider this rare entity in the differential diagnosis with coronary ischemia.² Echocardiography and transesophageal echocardiography (TEE) are usually used to assess cardiac and paracardiac lesions.^{2,3} However, CT allows an accurate study of these lesions and above all their topographic relationship in order to plan the most appropriate surgical approach.^{4,5} MRI may also play a role when differential diagnosis from other mediastinal masses is difficult.^{3,5}

For an accurate interpretation of this case study, it would be important to examine the following three questions:

1. In Figure 1 the authors affirm that the coronary angiogram showed severe compression of the ostium of the left main coronary artery. With the suspicion of external compression, a CT or TEE performed before the operation might have clarified the nature of the compression.
2. In the hypothesis that the coronary stenosis was caused by an extrinsic compression from a mass revealed by a perioperative TEE, were the bypass grafts necessary or could it

have been better to check the patency of the left coronary artery after cyst removal?

In the discussion section the authors assert that the etiology of the mass was uncertain, but in our opinion this does not justify the bypass, especially because the coronary anatomy was normal.

3. Finally, we believe that the second cyst (sized 5 × 3 cm) was large enough to have been detected by the perioperative TEE, avoiding the second operation.

Actually, the thoracic CT and the endoscopic ultrasound allow the surgeon to have a correct preoperative diagnosis in the mediastinal lesions to use the most appropriate surgical approach.⁵

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