Reply to the Editor:

My colleagues and I read with interest the comments by Cioffi, De Simone, and Ciulla in response to our article, "A Near Fatal Presentation of a Bronchogenic Cyst Compressing the Left Main Coronary Artery."¹ This article concerns the case of a 48-year-old woman with acute, severe coronary ischemia, which subsequently appeared to be due to left main coronary artery compression from a bronchogenic cyst. The patient had a magnetic resonance imaging (MRI) scan in the postoperative period, which demonstrated another bronchogenic cyst. This was removed at a second operation.

We would like to respond to the three points made by Cioffi, De Simone, and Ciulla in turn.

1. Figure 1 in our article shows a severe ostial *stenosis* of the left main coronary artery. At the time of the coronary angiogram, there was no suspicion that this was from extrinsic compression. This was assumed to be due to coronary artery disease, which is the most common cause of left main stem coronary artery stenosis. We agree that if one suspected external compression, a computed tomogram (CT) or transesophageal echocardiogram (TEE) before the operation might have been helpful in ascertaining the nature of the compression. Our patient did, however, have acute, severe cardiac ischemia with three episodes of ventricular fibrillation (one episode after insertion of an intra-aortic balloon pump), and under these circumstances, a preoperative CT or TEE would have been totally inappropriate.
2. At the first operation, a perioperative TEE showed a cystic mass compressing the left atrium and the ostium of the left main coronary artery. The mass, which contained pus, was not completely excised, inasmuch as we were unclear as to its etiology and gaining access to

it in the transverse sinus was difficult. Under these circumstances, and in view of the severity of the patient's presentation, we believed it was appropriate to perform the bypass grafts. Although the left anterior descending and circumflex coronary arteries were free of disease, the severe left main stem compression, seen angiographically, justified the bypasses. This was the safest thing to do. In our opinion, it would have been difficult to check the patency of the left main coronary artery perioperatively with TEE, with the patient supported by cardiopulmonary bypass and with an arrested heart, to check whether the external compression was relieved after removal of the mass.

3. A second cyst (5 × 3 cm) was identified in the subcarinal position, on an MRI scan of the chest postoperatively, necessitating a second operation via right thoracotomy. Cioffi, De Simone, and Ciulla may be correct in stating that this second cyst was large enough to be detected by intraoperative TEE. We have reviewed our TEE images, however, and have not been able to detect the second cyst, although a more thorough examination of the mediastinum by a TEE expert may have. Even if the second cyst was identified at the time of the first operation, I (the operating surgeon) would still not have attempted to excise it. The reasons, again, are that the etiology was unknown and the patient was in poor condition at the time of the operation. I suspect it would have also been difficult to undertake excision of the second mass via median sternotomy.

In conclusion, we agree that CT thorax and TEE are useful tools in the diagnosis of intrapericardial masses, as mentioned in our discussion, and that the correct diagnosis would allow the most appropriate surgical approach.

However, this is only suitable in elective, stable patients and, in our case, the delays in performing these investigations might have resulted in the diagnosis being made at autopsy.

Wael Ibrahim Awad, MD, FRCS
London Chest Hospital
London, United Kingdom

Reference

1. Azeem F, Rathwell C, Awad WI. A near fatal presentation of a bronchogenic cyst compressing the left main coronary artery. *J Thorac Cardiovasc Surg.* 2008;135:1395-6.

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SURGEONS' INFORMED CONSENT**To the Editor:**

Jeffrey Shuhaiber's "Tribute to our Fallen Comrades"¹ in the June 2008 issue of the *Journal* recounts the tragic story of the crash of the University of Michigan Survival Flight air ambulance into the waters of Lake Michigan 1 year ago. The twinjet Cessna Citation was returning in the early morning hours with the organs they had retrieved for a double lung transplant. Four university transplant team members and two pilots died. The story of the fallen comrades of Ann Arbor turned the world's attention to their heroic role in the warrior culture of surgery. In his eloquent tribute, Shuhaiber underlines the burden of risk, including the ultimate risk of death, that surgical teams accept in performance of their duty to retrieve organs for transplantation.

The burdens and risks of surgery are generally considered to be entirely on the patient's side. Lay and professional observers, lawyers, and ethicists commonly envision the surgeon's role as technical, almost analogous to that of a hairdresser who provides the cut specified by the customer. Surgical teaching about informed consent focuses discussion narrowly on explanation to the patient about the benefits and burdens of treatment.