lung was achieved. Thus, accurate oncologic resection was enabled.

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EDITORIAL COMMENTARY

Placing technique before judgment?

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The authors¹ describe a new application for a type of extracorporeal membrane oxygenation support of the cardiopulmonary process. The article is clear and certainly adds to the array of possibilities available to cardiothoracic surgeons in our quest to improve the health and lives of our patients. Because it is a case report, we have no long-term follow-up on the patient and no series to review to help us gauge the efficacy of this treatment modality in the long term.

Malignancy after lung transplantation is fairly common, occurring in approximately 4% of patients in the first year, and in 25% by year 10. Indeed, it is a common (nearly 10% after the first year) cause of death after transplantation. Not much can be found on review, regarding bladder cancer in the post-lung transplantation patient, but hematologic malignancy is the most common form of posttransplantation cancer, followed by skin and then other malignancies.

The most accepted form of treatment for malignancy after transplantation is careful reduction in immunosuppression, and it has mixed results.² Whether this approach was pursued was not addressed in the authors' report, but hopefully it was an important part of their treatment strategy. One should never consider the age, but rather the mileage, on a particular patient. It is easy to assume a 67-year-old man, now 8 years beyond a lung transplantation, who developed extensive bladder cancer requiring an exhaustive resection no more than a year before, and now has 4 discrete metastatic lung lesions, has accumulated more miles than

most his age. Despite fine efforts, it would be suspected that, statistically, this case has a fairly low chance of being cured; the patient came with a significant risk, and quite realized morbidity of 3 weeks of hospitalization.

In addition to the risk and morbidity, we know concern exists for the immunomodulation associated with cardiopulmonary bypass, and presumably extracorporeal membrane oxygenation, which may have further facilitated the spread of the disease or inhibited the patient's own metastatic disease defenses. At his age (mileage), the ability of this patient to return to a functional existence after such a procedure is questionable. The purpose of this editorial is to

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Central Message

Described is a useful technique for resection of otherwise unresectable lesions, but where should we draw the line on aggressive care?

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acknowledge, and indeed endorse, a great technique. For this patient, it may well prove to be a lasting and outstanding result.

The purpose is additionally to remind us all to question whether our efforts and resources are being given to patients who are most likely to receive long-term benefit from them. As medical practitioners, today we have more reason than ever to focus on the value of every treatment or procedure we consider, and to similarly consider the evidence behind any therapy. Although this case may prove to be a long-term

success, my most influential teacher might well have considered it a “triumph of technique over judgment” (J. Kent Trinkle, personal communication).

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