A bridge too far?

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Soft tissue sarcoma occurs in more than 8000 patients per year in the United States. Local control can often be achieved in soft tissue sarcoma, but metastatic disease continues to occur in 25% to 50% of afflicted patients. Because of the tumor's propensity for hematogenous spread, the most common site of metastatic involvement is the lung. Patients with local control of their initial tumor but with pulmonary metastasis will generally show less than 20% survival at 5 years without surgery, compared with slightly more than 50% survival with pulmonary metastasectomy.¹ Pulmonary metastasectomy is considered if the local tumor is controlled, the metastatic disease can be completely removed, and the risk to the patient is reasonable. Positive prognostic factors for survival are 2 or fewer metastatic lesions, no lesions larger than 2 cm, and no disease outside of the lungs; the number of pulmonary metastases is the strongest predictor.¹

Hashimoto and co-authors² present a 38-year-old man who had complete resection of a right hip osteosarcoma 16 months before presentation with hemoptysis. His physicians discovered an 11-cm right lower lobe lesion that also involved his left atrium and a 4-cm lesion in the left lower lobe. He underwent palliative intent radiation of 20 Gy to the right-sided lesions. Once the hemoptysis resolved, the patient was treated with 6 rounds of neoadjuvant chemotherapy with adriamycin and ifosfamide. After chemotherapy, the patient's lung lesions were reduced, and he was without extrapulmonary disease. With 2 of the 3 positive aforementioned prognostic factors, surgical resection would be reasonable if the team could completely resect both lesions with negative margins and at a reasonable level of risk to the patient. The surgical team operated using a well-thought-out strategy to achieve this goal; their method is worth considering by serious thoracic surgeons.

"A Bridge Too Far" refers to the 1974 book by Cornelius Ryan³ that tells the story of the failure of Operation Market Garden in World War II. The Allies planned to capture a number of key bridges in the occupied Netherlands, hoping to outflank the German defense forces and end the war before Christmas. The title references a quote from a commander who worries his troops will not be able to seize all

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Central Message

This article relates a uniquely challenging case, describing a creative technical tour de force. They show that innovation and technical mastery are thriving in thoracic surgery.

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the targeted bridges and fears they may be going "a bridge too far." Thus, "a bridge too far" has come to mean exceeding one's capacity for success.

Our thoracic tumor group has considerable experience with tumors requiring both cardiac and pulmonary resection⁴ and lung cancer requiring simultaneous cardiac resection.⁵ These are challenging cases, and strategic planning is imperative. Hashimoto and co-authors² describe an innovative approach to this difficult problem and achieved an outstanding outcome. Although we—and you—might have taken a different approach, these cases demonstrate how the innovative thinking of thoracic surgeons when faced with difficult and unusual problems can save the day. We congratulate Dr Hashimoto and colleagues² on successfully outflanking the sarcoma. Through strategy and skill, they saved the patient and avoided going a bridge too far.

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