FIGURE 1. Left station 5 hypermetabolic lymph node (white arrow) and presence of calcium on the aortic arch on (A) chest computed tomography scan and (B) positron emission tomography scan. C, Three-dimensional reconstruction of chest computed tomography scan revealing a penetrating atherosclerotic ulcer of the aortic arch (red arrow). D, Thoracic endovascular aortic repair with a membrane-covered stent-graft.

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REPLY: WHEN THERE IS A WILL, THERE IS A WAY

Reply to the Editor:

I would like to thank Soumagne and Fortin for their insightful comments.¹ The authors present a case of endoscopic ultrasound-guided transaortic biopsy of a station 5 lymph node that was complicated by an aortic ulcer requiring repair with an endovascular stent. They conclude that this procedure should be contraindicated in patients with aortic pathology such as calcifications, atherosclerosis, or vascular disease.

The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

When looking at the target lesion across a large vessel, an endosonographer should ask 3 questions.

- Do I really need to go there? In the case described, a 10-mm left upper lobe lesion was associated with a mildly hypermetabolic and relatively small-sized station 5 lymph node. All other sampled mediastinal lymph nodes were negative for metastasis. Was a biopsy of station 5 going to change management? Most tumor boards will support upfront resection of a left upper lobe lung cancer with an isolated metastasis to station 5 because the prognosis is very close to that of N1 disease.
- Am I well equipped to get there? In the article by Molina and colleagues² the authors describe performing the echo-endoscopic procedures using a linear ultrasound array scope. These scopes are designed to be used in the esophagus by virtue of large balloons, multiple degrees of freedom on the articulating tip, the ability to lock the position of the scope in place before threading the needle, and the ability to use a long needle (8 cm) to reach distant targets. This equipment not only allows superior assessment of the biopsy window, but also allows for a safe and well-controlled sampling. Soumagne and Fortin do not describe the equipment they used, but one can infer that it was an endobronchial ultrasound positioned in the esophagus, as has become routine practice in the realm of interventional pulmonology. Transaortic transesophageal biopsies should not be attempted with equipment that is not designed to work in the esophagus.
- Can I cross there and back safely? Most authors will agree that aortic calcifications visible on computed tomography and/or endosonography are an absolute contraindication to transaortic biopsy due to the risk of aneurysm or stroke. I am in complete agreement with Soumagne and Fortin that such a biopsy should not be attempted, and strong caution should be advised.

Crossing the aorta is akin to crossing a busy street. Endosonographers must ask if they really need to go there, whether they are equipped to do so, and whether they can get back safely. If so, then when there is a will, there is a way.

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REPLY: TRANSAORTIC TREPIDATION

Reply to the Editor:

Drs Soumagne and Fortin from the Université Laval in Québec submitted a Letter to the Editor that enhances our understanding of the caveats regarding transvascular ultrasound-guided needle puncture for the biopsy of mediastinal and pulmonary lesions.¹ This is a response to an original manuscript written by Molina and colleagues² from the group at Centre Hospitalier de l'Université de Montréal exploring the feasibility and safety of this procedure.

This letter provides additional color to illustrate a feared complication of transaortic needle puncture. Molina and colleagues cautioned endoscopists in the original manuscript regarding traversing a calcified, aneurysmal, or atherosclerotic aorta, although they did not specify a clear algorithm. Therefore, repercussions were only theoretical. Soumagne and Fortin describe a case in which a level V lymph node was accessed through a transaortic approach with a 22-gauge needle in 3 passes. The aorta was noted to be calcified and atherosclerotic. Diagnostic tissue was achieved with no immediate complications, yet the patient subsequently developed a penetrating ulcer of the aortic arch with a mediastinal hematoma requiring endovascular repair. She recovered and went on to receive definitive chemoradiation for non-small cell lung cancer.

We are thankful that Drs Soumagne and Fortin elected to share their experience. It illustrates 2 points. First, a strong sense of foreboding should precede transaortic puncture through 2 walls of a diseased vessel. Of course, this singular case can only be considered anecdotal. However, cardiothoracic surgeons have intimate experience with the consistency of a diseased aortic wall and understand the potential consequences of disrupting its fragile layers. Not all cases will be straightforward, and good clinical judgment regarding consequences of completing or aborting a procedure will be required for any specific scenario. We also do not understand how long to observe a patient in recovery or how to recognize a vascular complication early. Fortunately, this particular patient presented with dysphagia and pain.

Second, this case allows us to reflect on any purely diagnostic procedure that entails risk. It is critical to ensure that