restore proper ventilation. Tracheoplasty with the esophageal wall was initially described to treat patients with congenital tracheal stenosis. Niwa and associates⁵ first reported the delayed treatment of an iatrogenic tracheobronchial injury with this method.

The operative technique we used differed from the one described by Niwa, who sutured the left and right edges of the trachea to the esophagus.

This is, to our knowledge, the first report of such a technique being successfully used in an emergency to repair a tracheobronchial rupture. We used this procedure because it was the most expeditious way to achieve a perfect air seal. In addition, the abundant blood supply to the esophageal wall makes it superior to an isolated pericardial graft to repair such a large defect. The esophageal wall was completely epithelialized 3 months after the procedure was performed, and the absence of tracheobronchial stenosis by granulation tissue confirms that this technique can be used safely in young children.

In conclusion, esophageal tracheobronchoplasty is a simple and efficient method to obtain immediate and complete reconstruction of the tracheal wall in cases of

extended burstlike trauma with further ad integrum recovery of both airway and esophageal functions.

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LONG-TERM SURVIVAL AFTER RESECTION OF A MEDIASTINAL METASTASIS FROM A RENAL CELL CARCINOMA

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Twenty-five percent to 30% of patients with a renal cell carcinoma have a metastasis by the time the renal cell carcinoma is diagnosed, and 30% to 50% of these patients subsequently have pulmonary metastases.^{1,2} Pulmonary metastases are common in patients with renal cell carcinoma and usually consist of multiple nodules of varying sizes that develop in both lung fields. In contrast, mediastinal adenopathy but no pulmonary parenchymal disease is a rare manifestation of intrathoracic involvement. Herein we describe the case of a patient with a mediastinal metastasis of a renal cell carcinoma. A mediastinal lymph node resection was performed, and 6 years after the operation the patient remains alive.

Clinical summary. Twelve months before admission to our facility, our patient, a 50-year-old man, had undergone a left nephrectomy. He appeared to be doing well after the operation until a routine follow-up chest radiograph revealed a right paratracheal adenopathy (Fig. 1).

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Chest computed tomography (CT) showed paratracheal adenopathy (Fig. 2) but no parenchymal metastases. Bronchoscopic examination revealed nothing abnormal and cytologic studies of sputum and bronchial washings revealed no contributory findings. Other tests, which included abdominal CT scans, brain CT scans, gallium scintigraphy, and bone scintigraphy, showed no evidence of any other tumors.

Thus thoracotomy was performed and the mass, located between the trachea and the superior vena cava, was excised. The tumor, measuring 58 × 55 × 35 mm, was encapsulated and easily resected, and a subsequent pathologic examination confirmed that it was a metastatic, lymphoid tissue renal cell carcinoma. The patient was given no postoperative therapy and to date, 6 years after the operation, has had no recurrence of tumor.

Comments. Pulmonary metastasis of a renal cell carcinoma itself is an initial feature of the disease in only 2% of cases and in such cases usually appears as multiple nodules in both lung fields.² Patients with renal cell carcinoma who have no parenchymal abnormalities but do have a hilar or paratracheal adenopathy, indicating intrathoracic involvement of the renal cell carcinoma, are rarely encountered. In a series of 1451 patients, only 75 (5%) were found to have a mediastinal adenopathy, whereas more than 90% had pulmonary parenchymal metastases and no isolated lymph node involvement in the chest cavity.³ The 5-year survival of patients with unresected metastatic renal cell carcinoma is only 2.7%.⁴ As for treatment of patients with metastatic renal cell carci-

Fig. 1. A well-defined mass in the mediastinum.

noma, chemotherapy, radiation therapy, and/or immunotherapy, single or in combination, have not been found to be effective; resective surgery still remains the best procedure for patients with a limited metastatic renal cell carcinoma. Cerfolio and associates⁵ reported that patients treated by resection of a solitary pulmonary metastasis had a 5-year survival of 46%.⁵ Also, the 5-year survival of 41 patients with renal cell carcinoma undergoing surgical resection of a solitary metastasis in the lung, cranium, abdomen, pelvis, neck, or extremity was found to be 31%.⁶ Although patients having renal cell carcinoma with a lymph node metastasis were not among the 41 just mentioned, these findings indicate that aggressive surgical treatment of isolated metastatic renal cell carcinoma is of benefit. The outcome of mediastinal metastasis not only of renal cell carcinoma but also of infradiaphragmatic malignancies is generally poor. So far as we can determine, our patient is the first reported case of long-term survival after

Fig. 2. CT scan shows a mass located between the superior vena cava and the trachea.

resection of solitary mediastinal lymph node metastasis of renal cell carcinoma.

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AORTIC VALVE-PRESERVING PROCEDURE FOR ENLARGEMENT OF THE LEFT VENTRICULAR OUTFLOW TRACT AND MITRAL ANULUS

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Tunnel subaortic stenosis is often a component of Shone's syndrome and therefore may be associated with mitral stenosis and hypoplasia of the mitral annulus.¹ It is also often, although not always, associated with valvular aortic stenosis. Patch enlargement of the ventricular septum, which forms the anterior wall of the left ventricular outflow tract, with preservation of the aortic annulus and valve ("modified Konno procedure"), is a useful procedure for management of tunnel subaortic stenosis when the aortic annulus and mitral annulus are of adequate size. However, when the mitral annulus is hypoplastic and must be enlarged to accommodate an adequate-sized prosthe-