average life expectancy is 8 months, although occasional long-term survival as long as 96 months has been reported.

The present case is unusual for the age of presentation and the short duration of the unique symptom, thoracic pain, which had started only hours before hospital admission (the reported mean duration of symptoms before diagnosis in these tumors is 6 months). Plain chest radiographs and computed tomographic scan were diagnostic for extrapleural thoracic wall tumor of nonosseous origin and fine-needle aspiration puncture was diagnostic for a small-cell tumor, with a high suspicion of malignancy. Altogether, the diagnostic workup led to what is currently considered to be correct initial treatment, completed before the histologic diagnosis was obtained, with the aggressive combined therapy this kind of tumor requires. Local infiltration was limited, an unusual feature in Askin's tumors. This may be related to the early diagnosis and prompt treatment.

We conclude that Askin's tumor should be considered as one etiologic possibility in a small-cell tumor of the thoracic wall at any age. Patients with such tumors consequently should be treated by means of prompt and wide local excision.

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Indications for median sternotomy for acute traumatic rupture of the descending thoracic aorta

To the Editor:

The standard approach for traumatic rupture of the descending thoracic aorta is through a left thoracotomy. In some instances, however, because of the severity of the associated lesions or the complexity of the aortic injury, this approach may be inadequate.

Between 1980 and 1990, we treated 22 ruptures of the descending thoracic aorta. In three cases, we had to perform aortic repair through a midsternotomy instead of the usual left thoracotomy. This approach necessitates cardiopulmonary bypass (Fig. 1) to gain access to the descending aorta. Normothermic perfusion is started in the ascending aorta. The left lung must be perfectly deflated and ventilation must be stopped. The rupture is controlled by proximal crossclamping of the aorta between the left carotid and left subclavian arteries, the latter being clamped separately. The left pleura is then opened and...
blood is emptied. The left lung is lifted above the heart and the descending aorta is clamped below the rupture. At this stage, femoral perfusion is started.

CASE 1. In December 1983, a 52-year-old man was admitted to our department after a motor vehicle accident. He had several injuries, including a flailed chest from the third to the sixth left rib, a left acetabulum fracture, and a complex facial injury. The chest radiograph showed left-sided hemothorax and aortography revealed a rupture of the aortic isthmus with arch involvement (Fig. 2). Because of the complexity of the lesion, the operation was performed through a sternotomy with cardiopulmonary bypass.

After opening the left pleura, we faced a complete transection of the aortic isthmus with a longitudinal tear of the transverse arch concavity. A Dacron graft was placed in the descending aorta and the longitudinal tear was repaired with interrupted sutures over Teflon felt pledgets. The postoperative course was obscured by an oligoanuria, which necessitated 7 days of hemodialysis. The head trauma included ocular wounds, which caused blindness. Eight years later, despite loss of vision, the patient is living a normal life.

CASE 2. In July 1986, a 19-year-old man was admitted to another hospital after a motor vehicle accident. He had multiple injuries including a major fracture of the pelvis. During the orthopedic procedure, hemodynamic instability with collapse prompted the surgeon to ask for a chest radiograph, which showed a complete left-sided hemothorax. The patient was immediately transferred to our center for treatment of a suspected rupture of the aorta. The patient arrived in the operating room in cardiac arrest. During cardiopulmonary resuscitation, a sternotomy was performed. When the pericardium was opened, the heart protruded as a result of the pressure of the

![Extracorporeal circuit](image1.png)

Fig. 1. Extracorporeal circuit.

![Aortogram](image2.png)

Fig. 2. Aortogram shows rupture of the aortic isthmus with transverse arch involvement.
Fig. 3. Myelograph shows spinal cord compression related to luxation of spine.

hemorrhage. This was enough to restore efficient cardiac activity. Extracorporeal circulation was started. The left pleura was then opened and several liters of blood were sucked out. The aortic isthmus was totally ruptured. The repair necessitated the placement of a Dacron graft. This patient is now leading a normal life at 5 years of follow-up.

CASE 3. In July 1990, a 28-year-old man was admitted to our department after a motor vehicle accident. On clinical examination, the patient was found to be paraplegic. The chest radiograph showed a mediastinal enlargement and a fracture of the sixth thoracic vertebra. Aortography revealed a transection of the mid descending aorta. Because of the spinal lesion, the patient was operated on in a rigid shell, which made thoracotomy impossible. A sternotomy was performed with cardiopulmonary bypass. At the level of rupture, the dorsal aspect of the aorta was incarcerated between the luxated vertebral bodies of the sixth and the seventh thoracic vertebrae. The aorta was repaired with a Dacron graft. Postoperative myelography showed a spinal cord compression related to the luxation of the spine (Fig. 3). The patient recovered totally from his paraplegia and was discharged 75 days later. Sixteen months after his accident, the patient is living a normal life.

Obviously, the exposure of the descending thoracic aorta is better through a left thoracotomy than through a median sternotomy. Use of the median sternotomy approach should be rare. However, we believe that it is an alternative in the most severe cases of acute traumatic rupture of the descending thoracic aorta: total rupture of the aorta, associated unstable spinal or pelvic fracture, and associated injuries of the transverse aortic arch.

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Extension of tissue survival time in multiorgan block preparation with a delta opioid DADLE ([D-Ala², D-Leu⁵]-enkephalin)

To the Editor:

In 1988, we¹ reported our results with a newly developed, autoperfused, multiorgan block preparation for long-term organ