The Journal of Thoracic and
Cardiovascular Surgery
February 1995

the "better patient selection" excuse for defining the future role of skeletal muscle assistance.

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12/8/60675

Aortopulmonary paraganglioma, a rare tumor

To the Editor:

I read with interest the letter on aortopulmonary paraganglioma by Castañon and associates,[1] who referred also to our case of intrathoracic chemodectoma (or paraganglioma) with multiple localizations.[2] I would like to recall the Carney triad of extraadrenal paraganglioma, pulmonary chondroma, and gastrointestinal leiomyo(sarco)ma. After reviewing the clinical data and the available histologic data on our case, Carney included our case in a series of patients with the triad from the Mayo Clinic and from the literature.[3]

Our case concerned a female patient who underwent at the age of 31 years a resection of an anterosuperior mediastinal chemodectoma. An esophageal anomaly had been discovered at the age of 16 years, during an episode of vomiting, but because the patient was afterward asymptomatic, she refused any further investigation of the esophagus. Seventeen years later the patient had a second operation. An aortopulmonary chemodectoma was resected and a pulmonary osteochondroma of the lingula was enucleated. The esophagus was not explored according to the wish of the patient. Two years later a small tumor in the left upper lung lobe was visible and was considered to be a new or recurrent benign pulmonary hamartochondroma, but again 2 years later an inoperable squamous cell carcinoma of the left main bronchus was discovered and the patient died 3 months later at the age of 52 years. Postmortem examination was refused by the relatives, so that the histologic type of the esophageal tumor is still unknown. We believed that the long-lasting esophageal anomaly was a benign leiomyoma and considered that our patient had the Carney triad.

With regard to the case of aortopulmonary paraganglioma reported by Castañon's group,[1] I have some recommendations and some comments.

I recommend regular follow-up of the patient, exclusion of other localizations of the paraganglioma, and exclusion of the triad of Carney. There is no chronologic sequence in the appearance of these three tumors, and their occurrence is more than coincidence.[3] Moreover, malignancy of each part of the triad is possible.[2, 3]

The risk of lung cancer is increased in patients with chondromatous hamartoma, whether the hamartoma itself or the fibrous scar or whether both tumors have common risk factors.[4] The spatial association was present in our case, and the question arises whether the enucleation of a hamartoma should not be altered in a segmental resection. In our case a new small tumor appeared 2 years after the enucleation and was, without proof, considered to be benign, but another 2 years later lung cancer was discovered in the same area.

Finally, patients with pulmonary hamartoma have a high incidence of associated anomalies and benign tumors but also an increased susceptibility to development of malignant tumors. Therefore, the clinical significance of pulmonary hamartoma is in the workup and lifelong follow-up of those patients.[5]

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12/8/55995

Anomalous origin of the left coronary artery from the pulmonary artery: New technique or modification of "old" technique

To the Editor:

We read with interest the article by Tashiro and associates,[1] "Anomalous Origin of the Left Coronary Artery