we continue to recommend rebiopsy of the 2R, 4R, and 4L stations through thoracotomy or through video-assisted thoracoscopic surgery.

The authors’ second question concerns the oxymoronic nature of the term standard-ized uptake value or maximum standardized uptake value (maxSUV). The authors state that “maxSUV is not standardized among different PET scanners and centers, making comparison and adoption of the proposed values by other institutions impossible.” We strongly but amicably disagree with this statement. First, the percentage change takes into account most of these variables, and this is why we recommend the repeat PET scan to be performed at the same center using the same techniques as the initial staging PET scan. Second, after much investigation and discussion with PET engineers, designers, and technicians, as well as expert nuclear radiologists, across the world, we are told that the difference in the maxSUV of a patient’s cancer on a PET scanner in Italy might only be up to 20% different if the patient had been scanned in Birmingham, Alabama. It is true that 20% is not negligible, but this is the upper end of the discrepancy. Many steps have already been implemented to limit these differences and to promote the standardization of the PET techniques and thus the maxSUV values. Finally, because we recognized this as a possible limitation to the everyday clinical applicability of our data, our future studies, some of which have been completed, have focused on ways to account for these differences. For instance, in this article we use the percentage change of the maxSUV of the primary tumor and of the involved mediastinal lymph node. We also have studied the use of the ratio of the maxSUV of the tumor to the N2 nodes to help predict metastatic disease. When that ratio is 0.6 or greater, there is an 85% chance the node is malignant, and this holds true for many different centers.2 This obviates the need for absolute values and takes into account the differences in max-SUVs across different centers. Finally, we are also studying the ratio of the size of the tumor to the maxSUV value of the tumor.

The third and final question posed concerns the increasing use of endoscopic ultrasonography-guided fine-needle aspiration (EUS-FNA). We have studied and written extensively on EUS-FNA3,4 and have used it as our first line of biopsy for N2 nodal biopsy in patients who have suspicious lymph nodes metastasis in posterior (7, 8, and 9) stations. Since 2001, we have used EUS-FNA first so as to reserve the mediastinoscopy for after induction chemoradiotherapy. We also use repeat EUS-FNA in those patients as well, as we have described in our articles. However, the authors did not note the downside of this strategy, which is that one might miss unsuspected N3 disease initially by not using mediastinoscopy. The incidence of unsuspected N3 disease is higher in patients with multinodal N2 disease as well. Finally, EUS-FNA is great for the 7, 8, and 9 stations but is blind in most endosonographer’s hands for the 2R, 4R, 2L, 5, and 6 stations. I greatly appreciate the authors’ thoughtful and insightful letter, and I agree with the majority of their comments.

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Ascending–descending aortic bypass with the aid of a heart-lifting device
To the Editor:
We read with interest the article “Ascending–descending aortic bypass with the aid of a heart-lifting device” by Aris and associates.1 We had an opportunity to use the technique in the management of a 15-year-old girl. She had arch reconstruction with pulmonary artery banding through a thoracotomy at the age of 8 months for type B interruption with ventricular septal defect. Six months after the procedure, she had undergone pulmonary artery debanding with ventricular septal defect closure. She had narrowing across the arch repair site, with a gradient of 80 mm Hg across the stenosed segment and significant left ventricular hypertrophy.

In view of her previous operation, it was decided to perform ascending–descending aortic bypass during cardiopulmonary bypass with a beating heart. An 18-mm Dacron tube graft was anastomosed to the descending aorta with a heart-lifting device (Starfish 2; Medtronic, Inc, Minneapolis, Minn) to keep the ventricular mass out of the way during the operation (Figure 1). The descending aorta was approached from the posterior pericardium. The stays on the margins of the pericardium can also be used to provide additional retraction during exposure. We placed the graft lateral to the right atrium within the pericardium because we considered that the tie of the graft would be better in this position. The patient had uneventful postoperative recovery with no residual gradient between the upper and lower limbs at the time of discharge.

Other techniques have been described for performing bypass in the management of complex recoarctation. The lateral isthmic bypass2 between the left subclavian artery and the descending aorta has the advantage of being an “anatomic” bypass. The disadvantage of the technique in our patient was that it would require a repeat thoracotomy, and there

Figure 1. Use of the Starfish 2 device (Medtronic, Inc) for ascending–descending aortic bypass for retracting the ventricle.
was concern about the adequacy of the subclavian artery as the inflow segment. Moreover, we would be lacking the safety afforded by cardiopulmonary bypass. Ascending–descending aortic bypass has also been described by using the right thoracotomy approach.³

We believe that cardiopulmonary bypass provides safety in the presence of significant left ventricular hypertrophy. Use of a heart-lifting device makes the operation simpler by freeing the assistant’s hand and by enabling the procedure to be performed with a beating heart. Strategically placed pericardial stays can also help in keeping the heart mass out of the way during the procedure.

**References**


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**Reply to the Editor:**

We thank Dr Krishnan and colleagues for their letter, which proves that resourceful surgeons can be found worldwide. They report the use of a heart-lifting device to perform an ascending–descending aortic bypass in a 15-year-old girl with previous aortic arch surgery. Because of previous thoracotomy, as in our reported case,¹ they elected this type of bypass, which has been increasingly used for reoperations in the aortic arch and isthmus in view of its excellent long-term results.² The figure in the letter is almost identical to the one appearing in our article, except for the fact that they routed the graft around the right margin of the heart. Direction of the graft should conform to the individual anatomy encountered in each case. Again, the excellent exposure achieved with the use of a lifting device to retract the heart is shown and demonstrates that there is no need to have an assistant’s hand cramming the operative field. This report enhances the feasibility of the procedure and might help to popularize it. We encourage surgeons to try it and foresee that it will be performed without the use of cardiopulmonary bypass in selected cases.

**References**
