ulation in almost 90% of patients and warfarin in 70%, the text later inappropriately states that of the patients who were cardioverted after a negative TEE, that “None received warfarin.” It is important for the medical community to be aware that the use of TEE to guide early cardioversion has only been proved safe when performed with a therapeutic prothrombin time/international normalized ratio or partial thromboplastin time at the time of TEE and extending through cardioversion to 1 month after cardioversion.

Such a strategy for early cardioversion has been shown to have a safety profile similar to conventional therapy of 3 to 4 weeks of warfarin prior to cardioversion.2 Cardioversion without this anticoagulation strategy has been associated with thromboembolism despite a “negative” TEE,4,5 and should be discouraged. As to whether these adverse events are the results of a failure of TEE to identify atrial thrombi or the results of thrombus formation after direct current cardioversion6 is uncertain.

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REFERENCES

<table>
<thead>
<tr>
<th>Lung-lobule</th>
<th>Upper, %</th>
<th>Medium, %</th>
<th>Lower, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left</td>
<td>56/46</td>
<td>5.81/9.7</td>
<td>1.65/7.3</td>
</tr>
<tr>
<td>Right</td>
<td>26.6/26.4</td>
<td>6.16/7.3</td>
<td>3.65/6.32</td>
</tr>
</tbody>
</table>

spicular nodule located in the posterior segment of the left upper lobe with extensive severe destruction of lung parenchyma, Transthoracic fine-needle biopsy was ruled out because of the high risk of pneumothorax. The results of ventilation/perfusion (V/Q) scintigraphy are summarized in Table 1. Technetium tetrofosmin single-photon emission CT showed radionuclide uptake by the nodule.

We performed a sparing left thoracotomy involving lung volume reduction surgery (LVRS) of approximately 20%, consisting of wedge resections of the inferior left lobe, where the V/Q was lower.

Wedge resection of the nodule was also carried out. The patient was extubated in the operating room and the postoperative period was uneventful. The biopsy showed a poorly differentiated adenocarcinoma. The patient was discharged after 9 days of the operation. Two weeks after the operation, he had an FEV1 of 696 (22%), FVC of 1,840 mL (46.2%), PO2 of 67 mm Hg, Pco2 of 43.9 mm Hg, and moderate dyspnea.

Over the past year, several articles have been published dealing with LVRS involving thoracotomy, stenotomy,13 and thoracoscopy,4,5 either as surgical treatment of emphysema or as a bridge to transplantation.16 The criteria for patient selection for application of this technique have also been reported.2,7 Nevertheless, we are unaware of the existence of any reference associating LVRS and lung cancer surgery.

In our opinion, the improvement in respiratory function obtained with LVRS demonstrates that patients with emphysema and lung cancer, currently considered inoperable, may be considered candidates for wedge resection of the tumor and LVRS of the most damaged portions of the parenchyma.

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Lung Volume Reduction Surgery

New Expectations in the Surgical Treatment of Lung Cancer

To the Editor:

We have read with interest the editorial written by Dr. Olsen (CHEST, 1995; 106:298-99), as we have recently dealt with a case that illustrates the same situation.

A 61-year-old man with a history of severe emphysema with a FEV1 of 660 mL (21%), FVC of 1,680 mL (42%), Pco2 of 56 mm Hg, Pco2 of 42.2 mm Hg, and diffusion of carbon monoxide of 37%. The patient, a former smoker of 30 cigarettes per day, also had a peptic ulcer. He suffered from mild exertional dyspnea, requiring supplemental oxygen at home, and he presented with chronic ashenia and productive cough. Radiologic examination disclosed a solitary pulmonary nodule, which had not been previously present.

Preoperative CT revealed the presence of a solitary 25-mm long

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Communications to the Editor

1664

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