

coarctation is managed mainly in infancy by resection and end-to-end anastomosis [3]. This is easy because of elastic tissues and removes ductal remnants. In the 1950s there was a long waiting list for advanced surgical methods and some patients became adolescents. In these patients, especially when longer aortic segments are affected, resection and implantation of an interposition graft is necessary. This method produces less stress on the suture line and on the normal aortic wall. It is questionable whether commonly used prosthetic materials can provide as good long-term results as homografts. But the lesson we can learn from the follow-up of our patients is that we can expect extremely good long-term outcomes when homograft tissue is implanted.

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Preoperative Preparation of Patients With Myasthenia Gravis Forestalls Postoperative Respiratory Complications After Thymectomy

To the Editor:

Kas and colleagues [1] reported a 10-year retrospective review of early complications after standard or extended transsternal thymectomies for myasthenia gravis (MG) in 324 patients. Fifty-eight percent of them had moderately severe or severe MG. All of the patients were treated preoperatively with an anticholinesterase; 35 also received plasmapheresis; 34, immunosuppression; and 13, irradiation. Preoperative pulmonary function status was not defined. Postoperatively, the cholinesterase inhibitor was withheld for 48 hours during which time the patients were mechanically ventilated. At that point, the patients were extubated, and a standardized protocol of anticholinesterase medication was instituted.

Seventy-one patients (22%) experienced respiratory insufficiency, 49 of whom required reintubation of tracheostomy. In this abstract, Kas and coauthors concluded as follows: "The excessive incidence of respiratory insufficiency and airway-associated morbidity was potentially related, at least partially, to prolonged mechanical ventilation and withdrawal of anticholinesterase medication." They recommended that the duration of postoperative ventilatory support be reduced and the withdrawal of the anticholinesterase be hastened.

Kas and coworkers are to be congratulated for their detailed analysis of the postoperative complications, and we support their recommendations that this type of analysis be routinely performed when reporting the results of thymectomy for MG [2]. We are concerned, however, with the incidence of respiratory complications, disagree with their preoperative preparation program, and do not believe the proposed revision of their perioperative protocol is the solution. In our opinion, most postoperative respiratory complications in the patient with MG are directly related to inadequate preoperative preparation. The use of cholinesterase inhibitor alone only temporarily masks the weakness of MG, and under these circumstances, patients with respiratory and oropharyngeal weakness preoperatively can be expected to have a high rate of postoperative respiratory complications.

Accordingly, most centers that treat patients with MG now recommend that these patients be made as free from respiratory and oropharyngeal weakness as possible preoperatively [3] and evaluate the patients with appropriate pulmonary function testing [4]. The use of plasmapheresis or intravenous immunoglobulin is usually recommended preoperatively for patients who have oropharyngeal weakness to achieve respiratory and oropharyngeal function that is as normal as possible; although immunosuppression is used by some, its role is less well defined [5, 6]. With this type of preparation, these patients can be expected to have a postoperative course similar to that of patients without MG undergoing the same type of surgical procedure. We recommend such a program to Kas and associates.

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