Survival after radical resection of cardiac sarcomas

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We read with great interest the review article from Ganesh Shanmugan about primary cardiac sarcomas, published in the June issue [1]. This review gives an extensive and comprehensive picture about the occurrence, diagnosis, therapy and outcome of primary cardiac sarcomas. However, we did not agree to the prognosis following surgical therapy. While it is obvious clear, that incomplete resection leads to a low survival rate of less than 1 year; we believe that outcome following complete resection is superior to the mentioned 24 months in the text.

In 2004, we published our results following radical resection of cardiac sarcomas [2]. Radical resection was often performed by auto-transplantation with reconstruction of the partly large defects with Dacron® and PTFE grafts [3,4]. From the 2004 presented patients [2] one died in the meantime, while the other are still alive without any occurrence of metastasis or local tumor recurrence. So far, with this radical approach, we were able to increase the median survival up to 45 months. Even reports of cardiac transplantation with perioperative chemotherapy in patients with sarcomas could only demonstrate a mean survival of 18 months [5]. We believe that a radial surgical approach in patients with primary sarcomas, even in advanced tumor progression stages, is the only therapeutic option for these often young patients.

References


Letter to the Editor

What is the risk that I will have a major complication after my valve operation?

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In a recent article comparing clinical outcomes of mechanical versus bioprosthetic valves, Kulik et al. [1] posed the above question. The authors reported the freedom from major adverse prosthetic-related events (MAPE) using Kaplan–Meier curves (a type of ‘actuarial’ analysis), and suggested that a randomized controlled trial would be the ideal method to address this question. In fact, although a randomized controlled trial would help to balance the difference in clinical characteristics between the two groups of patients, using Kaplan–Meier analysis still would not give the correct answer to the question. There is an established statistical method, ‘cumulative incidence’ analysis (often called ‘actual’ analysis in the cardiac literature), available to give an estimate of the probability of MAPE [2].

The actuarial method is correctly used to estimate the probability of death, which is an inevitable event; but it is necessary to use the ‘actual’ method to get the correct probability of an event that may itself be precluded by death. A specific feature of time-to-event data is censoring, which is applied to patients who have not yet had the event because they are either: (1) lost-to-follow-up before having the event; (2) free from event at the end of the study; or (3) precluded from having the event due to the occurrence of the competing risk of death. The Kaplan–Meier method assumes a censored patient is still at risk of having the event in the future; this is true if the event-of-interest is death. But for events like MAPE, death itself...