

¹ Williams AJ, Cayton RM, Harding LK, Mostafa AB, Matthews HR. Quantitative lung scintigrams and lung function in the selection of patients for pneumonectomy. *Br J Dis Chest* 1984;78:105-12.

**This letter was sent to the authors, who reply below.

Details of seven patients with technically resectable bronchial carcinomas

Patient No	% perfusion	Tumour size (cm)	Surgical outcome	Reason for inoperability
1	14	3	Resected	
2	26	9	Resected	
3	14	4.5	Resected	
4	4	5	Resected	
5	6	8	Not resected	Pulmonary artery and pericardial disease
6	24	Not assessed	Not resected	Invasion of aorta; subaortic lymph node disease
7	8	7	Not resected	Cardiac invasion and pleural effusion

SIR,—We are grateful for the opportunity of replying to the points made by Dr Williams and his colleagues. As we pointed out in our paper, the interpretation of any data used to predict resectability of bronchial carcinoma depends critically on the criteria used by individual surgeons to decide whether or not potentially curative surgery is technically possible. For this reason it is difficult to compare our results with theirs. The best index of successful resection would be information on survival, which they do not give. We pointed out that in our series only one of 10 patients in whom the preoperative perfusion of the affected lung was less than 25% of the total survived two years and we suggest that this supports the use of scanning in the assessment of operability. As with most investigations, the additional information given by scanning has to be interpreted in the light of other clinical, radiological, pathological, and functional data and whether or not a thoracotomy is performed will not be determined by the scan in isolation from other information. Our suggestions on the quantitative use of scanning in assessment of operability were in fact more conservative than the recommendations in some earlier studies.¹

We would agree entirely with Dr Williams and his colleagues on the value of scans in prediction of postoperative lung function² and exercise performance.³

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¹ Secker Walker RH, Alderson PO, Wilhelm J, *et al.* Ventilation-perfusion scanning in carcinoma of the bronchus. *Chest* 1974;65:660-3.

² Ellis DA, Hawkins T, Gibson GJ, Nariman S. Prediction of lung function after pneumonectomy for bronchial carcinoma. *Thorax* 1982;37:786-7.

³ Corris PA, Ellis DA, Nariman S, Gibson GJ. Use of preoperative perfusion scanning to predict exercise performance after pneumonectomy for carcinoma of the bronchus. *Clin Sci* 1983;65:39P (abstract).

Jaundice after open heart surgery: a prospective study

SIR—The article by Dr C-M Chu and others (January 1984;39:52-6) has prompted us to draw attention to the histological changes in the liver, and the medical counterpart, of the condition they describe following cardiac surgery. Undoubtedly their patients had "ischaemic hepatitis," a recognised cause of jaundice,¹ but one which we feel is underdiagnosed in the United Kingdom. We have seen four medical patients who have developed this entity. Three were associated with cardiogenic shock due to myocardial infarction and one with shock lung due to renal failure following repair of a ruptured abdominal aortic aneurysm. Invasive manometry in these cases revealed the following pathophysiological mechanisms to be involved: (1) a high right atrial pressure, which causes hepatic congestion due to impaired venous drainage; (2) prolonged hypotension leading to underperfusion of the liver; and (3) hypoxaemia despite supplementary oxygen. These findings are similar to those of Dr Chu and his colleagues.

Our patients survived from three to nine days after hospital admission and developed premortem bilirubin levels ranging from 135 to 475 $\mu\text{mol/l}$ (7.9 to 27.8 mg/100 ml) and AST levels ranging from 350 to 2360 IU/l. All the patients succumbed to their myocardial or pulmonary disease. At necropsy the livers showed marked venous congestion. The capsules were smooth and stretched. Microscopically the specimens revealed changes caused by ischaemia (fig). Owing to their location hepatocytes at the periphery of the liver acinus receive blood at a lower oxygen tension than those cells close to the hepatic artery. They are thus more susceptible to damage when hypoxia and hypotension are present, and when in addition there is failure of venous drainage extensive cell necrosis at the periphery of the acinus may occur. As bile flow is dependent on arterial oxygen tension hypoxia may lead to slowing of bile secretion and even cholestasis.² All of these changes were seen in our patients.

The elevated serum bilirubin and AST levels may lead the clinician to consider a diagnosis of viral hepatitis. Awareness of the possibility of ischaemic hepatitis should,