Case reports

Commentary

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The case reports by Zer *et al*,[1] Heriot and Wells,[2] and Keane *et al*[3] have two features in common. As with all case reports they deal with highly unusual situations but, more importantly, they concern the management of congenital abnormalities which either present in or may require surgical attention during adult life.

The management of oesophageal atresia can be complex. It is rarely possible simply to disconnect the frequently associated tracheo-oesophageal fistula and to restore oesophageal continuity by direct anastomosis of the oesophageal ends. If the oesophageal muscle coat is incised in a circular manner – a myotomy – the oesophageal mucosal tube elongates, providing the surgeon with a longer proximal oesophageal segment and increasing the possibility of direct repair. The alternative to a direct repair is usually to use an interposed segment of colon. This strategy, however, whilst adequate in childhood, may leave a dilated and immobile oesophageal substitute with stenotic proximal and distal anastomoses in adult life. This situation is difficult to manage and may require major surgery to resect the colonic segment and restore continuity by creating a gastric tube which is anastomosed to the cervical oesophagus. Primary oesophageal repair in infancy is therefore preferable. When, however, a myotomy has been used to create length, the unsupported section of mucosa may dilate or "balloon" above an anastomosis, particularly when a degree of anastomotic narrowing is present. Again, colon substitution would be an option but the use of a plastic repair procedure as described by Zer *et al* avoids the use of a colonic conduit and hopefully, therefore, the consequent problems that may present to adult surgeons as the patient grows.

Chest wall herniation and paradox due to congenital absence or atresia of a rib or to marked divergence between ribs is uncommon. Surgery to correct such a deformity for both cosmetic and functional paradox reasons is particularly rare. Heriot and Wells[2] have adapted a technique used for chest wall reconstruction following resection of malignant disease involving the chest wall to a congenital chest wall defect. Cosmetic considerations were of particular importance in this case but definitive repair of the chest wall defect also cured the paradoxical chest wall motion. This case serves as a reminder of the advantages of lateral thought which provided an elegant surgical solution to an uncommon clinical situation.

Significant haemoptysis presents a difficult management problem to the thoracic surgeon. All too often an allegedly significant degree of haemoptysis is associated with poor diagnostic information regarding the origin of the bronchial bleed and the nature of any coincident pathology. Bronchoscopy is frequently unrewarding as blood may be distributed throughout the bronchial tree. If there is no evidence of an obvious intrabronchial neoplasm, the cause is usually ascribed to the areas of probable cause such as bronchiectasis or putative abnormalities in the bronchial circulation. In the case described by Keane *et al*[3] the authors have identified and confirmed an accessory cardiac bronchus as the causative lesion. Resection of the bronchus corrected the problem. They remind us of the importance of being aware of the possibility of an accessory bronchus which should occur in between one in 200 and one in 400 patients. This report contains several lessons. It is clear that thick slice computed tomographic scanning is only a first pass investigation and repeated presentation with haemoptysis requires further investigation by a spiral examination. As they also observe, we must also be aware during the investigative process of the unusual – in this case the accessory cardiac bronchus. This is a rare and interesting case which clearly identifies the need to consider the possibility of an accessory bronchus as a cause of haemoptysis. It is also equally clear, however, that the likelihood of this origin is vanishingly low – hence this report – and, from a surgical perspective, the important consideration must continue to be that common things happen commonly.

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1 Zer M, Freud E, Grozovski S. Oesophageal plastic repair for symptomatic ballooning following circular oesophageal myotomy and correction of oesophageal atresia. *Thorax* 1997;**52**:487–8.
2 Heriot AG, Wells FC. An unusual case of flail chest: surgical repair using Marlex mesh. *Thorax* 1997;**52**:488–9.
3 Keane MP, Meaney JFM, Kazerooni EA, Whyte RI, Flint A, Martinez FJ. Accessory cardiac bronchus presenting with haemoptysis. *Thorax* 1997;**52**:490–1.