LETTERS TO THE EDITOR

Surgical treatment of carcinoma of the oesophagus and Laurence O'Shaughnessy

I read, in Mr Raymond Hurt's interesting historical review (July 1991;46:528-35), that Professor Ferdinand Sauerbruch had been given a pass to cross the British lines around Dunkirk in 1940, to try to save the life of Mr Laurence F O'Shaughnessy, who had been wounded in the chest. As I was 12 years old when my mother and I left our burning home in Dunkirk in May 1940 and as I am now a sexagenarian thoracic surgeon, everything that concerns both the battle of Dunkirk and the history of thoracic surgery is of interest to me. I wrote to Mr Hurt, who confirmed that his information was based on GG Jamieson's *Surgery of the Oesophagus*, and more precisely on a chapter written by Professor RG Elmslie, professor of surgery at Queen Elizabeth Hospital in Woodville, Australia.¹ The phrase reads: "The thin link between Sauerbruch and British oesophageal surgery started between the first and second world wars with O'Shaughnessy, who died of chest wounds on the beaches of Dunkirk before his old chief, Sauerbruch, given safe conduct through the British lines, could reach him."

I have been interested for a long time in the circumstances of the death of a brilliant young British thoracic surgeon, whose curved dissector we all use. I personally insist on its eponym as a daily mark of respect for the memory of a man who had started, in the 1930s, the surgical interest in coronary disease as well as in oesophageal cancer.

In the Imperial War Graves Commission's register of the names of those who fell in the 1939-45 war and have no known grave his name is written. He died on 27 May 1940, which is the very day when the British Expeditionary Forces were ordered to fall back on the Yser river line. I had been told years ago that Mr O'Shaughnessy was hit on

the beach while helping wounded men to embark into rescue boats and that he slumped into the water at once and disappeared. These circumstances are probably not correct, as he died on the day before the embarkation started from the beaches, either in the town or in the harbour. What is certain is that his name is engraved on Dunkirk's war memorial consecrated to soldiers whose bodies were never recovered (figure).

If his body remained lost, I doubt very much that Mr O'Shaughnessy had received medical care or that Professor Sauerbruch was called to help, even if in that tragic chaos a message could have been sent from Dunkirk to Berlin, received, answered, and transmitted to the allied troops around the town. In his memoirs,² Professor Sauerbruch does not mention the fact. Considering how he was keen on reminding the reader of his international links and deeds, being more discreet about his relations with the German Government, this is surprising. He writes about coming from Berlin to Holland, Belgium, and France later in June, to inspect military hospitals. There are proofs of links between surgeons from opposite belligerent countries during the two world wars, particularly through Switzerland; but most of them concerned professional information, especially on abdominal and brain wounds.

Perhaps Mr O'Shaughnessy's body was never found; perhaps it was unidentified and lies in one of those many graves where are written the moving words "Known unto God." In any case, may this letter say to British surgeons that their promising young colleague has not been forgotten in France and to British people that a war comradeship, twice sealed in blood, tears, and mud during a quarter of a century, is vivid in our hearts and must be remembered at a time when we are trying to build Europe together.

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1 Elmslie RG. Perspectives in the development of oesophageal surgery. In: Jamieson GG, ed. *Surgery of the oesophagus*. London: Churchill-Livingstone, 1988:3-8.

2 Sauerbruch F. *Mes souvenirs de chirurgien* (translated by Forsletter M). Paris: Denoël, 1952:257-60.

Pathological assessment of mediastinal lymph nodes in lung cancer: implications for non-invasive mediastinal staging

We read the article by Dr K Kerr and his colleagues (May 1992;47:337-41) with interest. We would like to reinforce the serious reservations raised about this paper by Mr David Kaplan in his editorial (p 332). The essential thesis of the paper appears to be that the size of mediastinal lymph nodes does not aid prediction of metastases from carcinoma of the lung. We would like to make three points: (1) The selection criteria for those patients studied has already excluded most patients with malignant invasion of the mediastinum and presumably larger lymph nodes and there is also a noticeable absence of smaller normal sized nodes in their sample. It is not surprising that the remaining patients do not show a correlation between size and malignancy. It has also long been known that 10-15% of normal sized lymph nodes contain metastases and are not detected by mediastinoscopy or computed tomography. (2) Although the authors are at pains to point out which node stations were sampled, they have not related this to the expected chain of spread of each tumour. (3) Most importantly, they have measured the wrong lymph node diameter. Computed tomography images in the axial plane cut nearly all lymph nodes through their short axes. Assessment of lymph node size is made from the *smallest* diameter. This is sensible when the normal elongated ovoid shape of a lymph node is considered. The width will increase in malignancy before the length and may be measured by computed tomography. The authors' use of the *maximum* diameter renders extrapolation of their results to preoperative staging erroneous.

Overall, we believe that this paper is misleading and that the authors have no grounds for their comments on mediastinal computed tomography. Better studies¹ have consistently shown the value of preoperative imaging.

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1 Buy JN, Ghossein MA, Poirson F, Bazot M, Meay E, Malbec L, et al. Computed tomography of mediastinal lymph nodes in non-small cell lung cancer. *Journal of Computer Assisted Tomography* 1988;12:545-52.

AUTHOR'S REPLY Concern has been expressed about the selection of patients in our study. The statement by Drs Weston and Goddard that we "excluded most with malignant invasion of the mediastinum and presumably larger lymph nodes" is categorically untrue. Only patients with unequivocal mediastinal adenopathy on plain chest radiograph were excluded by the referring physicians and thus were not entered into the study. As the authors will be well aware, such patients represent a small fraction of individuals with mediastinal adenopathy and would not be expected to skew our data significantly for mediastinal nodes in the range 5-45 mm. Furthermore, as we emphasised in the paper, it is in our very group of "potentially operable" patients that lymph node histology is relevant and we do not accept that this biases our results.

The number of lymph nodes obtained per patient is perhaps low, but this is the number

Mr O'Shaughnessy's name on the Dunkirk memorial.