CORRESPONDENCE

Care of Battlefield Injuries

TO THE EDITOR: During Operation Iraqi Freedom, an Iraqi combatant sustained substantial battlefield trauma to his right temporofrontal area, exposing the brain surface. He was brought to a surgical company of the U.S. 1st Marine Expeditionary Force. The operating room was in a tent 20 miles from the front lines. Scalp, bone, and dura were lost as a result of the impact of the projectile. The area was cleaned, and hemostasis was achieved with a combination of thrombin and electrocautery. Closing the wound, making it tight with respect to cerebrospinal fluid until transfer to the next echelon of care (200 miles away), became a problem. A sterile intravenous-fluid bag lining was fashioned to fit the shape of the wound and was sewed with a continuous polypropylene suture to obtain watertight closure (Fig. 1). Although the patient was successfully transferred to the fleet hospital, he eventually died from complications of the head injury.

Intravenous-fluid bags have been used previously in the closure of abdominal-wound defects[1] but have not been documented as neurosurgical aids. A flexible sterile bag could be an extra tool that

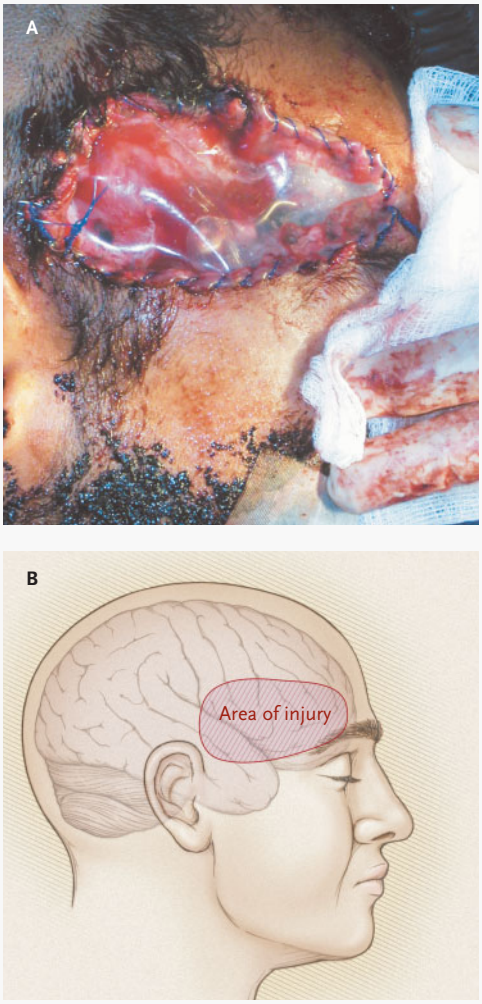

Figure 1. Closure of a Battlefield Head Wound.
Panel A shows a right temporofrontal defect closed with material from a sterile intravenous-fluid bag. Panel B is a schematic diagram of the defect.

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surgeons who lack needed materials could use until definitive care can be rendered.

V. Pothula, M.D.

U.S. Naval Hospital
Yokusuka, Japan
FPO AP 96350

Sanjay Gupta, M.D.

Emory University
Atlanta, GA 30322

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Intensive Therapy for Aggressive Lymphoma

TO THE EDITOR: Milpied et al. (March 25 issue)[1] provide further information about the benefits of high-dose chemotherapy plus autologous stem-cell support in the initial treatment of aggressive lymphoma. However, almost 50 percent of the patients were at low or low intermediate risk, according to the International Prognostic Index, and it seems that such patients may not benefit from intensive therapy.[2]

New strategies — for example, high-dose chemotherapy and autologous stem-cell support given initially or at the time of a first relapse, regimens with either higher doses or shorter intervals between cycles,[3] and strategies in which monoclonal antibodies are added to older regimens[4] — have been shown to improve the results achieved with standard-dose regimens. However, a recent meta-analysis of initial treatment of aggressive lymphoma with high-dose chemotherapy and autologous stem-cell support failed to demonstrate its superiority over standard-dose regimens.[5] In our opinion, initial high-dose chemotherapy and autologous stem-cell support should be reserved for use in patients at high intermediate or high risk, preferably in randomized trials, until studies that include some of the new strategies as a control are finished.

David Aguiar Bujanda, M.D.
Uriel Bohn Sarmiento, M.D.
Jose Aguiar Morales, M.D.

Hospital Universitario Gran Canaria Dr. Negrín
35020 Las Palmas de Gran Canaria, Spain
dagubuj@gobiernodecanarias.org

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TO THE EDITOR: The elegant article by Milpied et al. relates to a very important issue: the use of high-dose chemotherapy with stem-cell transplantation as first-line therapy in patients with aggressive lymphoma. However, their results may have very limited applicability. As the authors point out, treatment with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) is no longer the standard of care, since other therapies have been found to be superior in terms of event-free and overall survival for patients with aggressive lymphoma.[1,2] Moreover, when one of these combinations (doxorubicin, cyclophosphamide, vindesine, bleomycin, and prednisone) was compared with high-dose therapy, no benefit was observed in the transplantation group.[3] First-line high-dose chemotherapy can be, under certain circumstances, inferior to standard therapy for patients with this disease.[4] This consideration should not prompt one to question the merit of the work by Milpied et al., but it should alert clinicians to use caution when recommending high-dose chemotherapy as first-line treatment for patients with aggressive lymphoma, since such a regimen should not be considered the standard of care.

Javier Bolaños-Meade, M.D.

University of Maryland Greenebaum Cancer Center
Baltimore, MD 21201
jbola001@umaryland.edu

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