TABLE 1. Comparison of postoperative morbidity and mortality in patients undergoing bronchial sleeve resection (induction treatment versus no treatment)

	Overall (n = 106)		Induction (n = 56)		No induction (n = 50)		P value
	No.	%	No.	%	No.	%	
Perioperative morbidity							
Minor complications	29	27.5	12	21.4	17	34	.15
Major complications	7	6.6	5	8.9	2	4	.44
Late morbidity	6	5.6	3	5.3	3	6	.99
Perioperative mortality	5	4.7	2	3.6	3	6	.66

bronchial anastomosis in terms of late complications. Finally, the completeness of resection after lung-sparing resection in term of extension of mediastinal and hilar lymph node dissection was comparable to that obtained after pneumonectomy. At present, our experience with lung-sparing technique for lung cancer after induction treatment consists of 58 patients operated on through a period of 5 years, and it represent 54% of all sleeve resections performed during the same period (n = 106). A vascular resection was associated in 35% of cases. The overall postoperative morbidity rate and mortality of patients who underwent sleeve resection were 34% and 4.7%, respectively. Table 1 reports the comparison between the two groups (induction treatment vs no treatment).

This recent updated experience confirms our previous results and strongly supports the result of the article of Ohta and colleagues.¹ Bronchoplastic resection after induction chemotherapy is a safe treatment for locally advanced lung cancer, and it should be done whenever it is possible instead of pneumonectomy.

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Reply to the Editor:

My coauthors and I appreciate the comments by Veronesi and colleagues from the European Institute of Oncology. We find their results¹ to be consistent with ours,² with their latest study reconfirming our conclusion. They had excellent outcomes with a sleeve resection after induction therapy; however, the overall morbidity and mortality resulting from a primary operation were 44% and 6%, respectively, which were higher than those of Kutlu and Goldstraw³ (12% and 2%, respectively), who used the same continuous suture technique for the bronchial anastomosis as did Veronesi and colleagues.¹ The somewhat high morbidity rate in their control group may have had an influence on the statistical comparison analysis. Because surgical complications had a correlation with the extent of surgical resections,⁴ patients in their study who underwent a primary operation have probably received a more radical dissection of the tumor and invaded organs.

In our experience to date, the overall surgical morbidity of 22 patients who received preoperative induction therapy is 32% and that of 38 patients who underwent

a primary operation is 8%, and no postoperative deaths have occurred. Thus we believe that a sleeve resection is useful for any patient with centrally located advanced lung cancer in whom the anatomy is suitable for such a procedure. Further, we can insist, and are supported by the results of Veronesi and colleagues,² that a sleeve resection is a safe alternative to pneumonectomy, irrespective of preoperative treatment.

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Lack of evidence for vitamin C as acute vasodilator

To the Editor:

We read with interest the article by Drossos and colleagues.¹ They measured radial artery diameter before and after acute oral administration of vitamin C (2 g) in two separate studies. Study one was a comparison in healthy subjects comparing nonsmokers with smokers; study two was double-blind comparison with diltiazem.

The article raises several issues that we believe require clarification by the authors. First, the article does not contain any data on the diameter measurements. This is important, because previous studies^{2,3} that