difference between the median ratios of each aortic level within all age groups. Was there any correlation with the recoarctation or with the hypertension?

Factors influencing the process of recoarctation are tubular hypoplasia of the aortic arch, the surgical technique used, infective aortitis, complete resection of ductal tissue, suture material, suture technique, and width of the anastomosis. We do agree with their conclusion that none of the non-invasive methods used alone was sufficient to diagnose aortic recoarctation in every case, and they should be used as complementary methods. We would like to add that magnetic resonance angiography is indicated in all cases of suspected recoarctation. Currie and colleagues in 1985⁴ state that maximal catheter peak gradient equals 10.3 plus Doppler gradient.

What was the indication for surgical intervention? They have seen cases associated with endocarditis or mesenteric enteritis preoperatively or postoperatively. What are the methods of spinal protection they used to lessen the possibility of paraplegia, and what is the upper limit in the aortic clamp time?⁴

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Reply to the Editor:

In response to Dr Elsayed's questions, we would like to clarify that 111 patients had chest radiography postoperatively. In 57 (51.4%) patients the cardiothoracic ratio was 0.53 or less, and in 54 patients it was greater than 0.53. The left ventricular silhouette studied by the method was increased in 55 (49.6%) patients. The systolic ejection fraction (EF%) on echocardiography was available postoperatively for 111 patients (mean, 79% $\pm$ 6%; median, 79%; minimum, 45%; maximum, 92%). The left ventricular mass was also available for 111 patients (mean, 104.32 $\pm$ 28.24 g/m²; median, 100.00 g/m²; minimum, 50.00 g/m²; maximum, 220.00 g/m²). The mean left ventricular diastolic diameter available for 110 patients was 39.7 $\pm$ 9.1 mm (median, 38.0 mm; minimum, 20.0 mm; maximum, 63.0 mm). We decided to not include these variables because 78.8% of the patients had associated cardiac lesions that could interfere in the results. Furthermore, age and sex also interfere in the left ventricular mass, and the sample was not large enough to include all these variables. In relation to EF, we observed that in 24 patients with a mean age at the time of the operation of 14.9 $\pm$ 16.4 months (median, 6.8 months; minimum, 25 days; maximum, 4.6 years), EF before the operation (mean, 48% $\pm$ 10%; median, 48%; minimum, 29%; maximum, 65%) had a favorable evolution postoperatively (mean, 79% $\pm$ 5%; minimum, 67%; maximum, 90%).

The aortic ratio median behaved the same way independently of age at correction, meaning that it decreased progressively up to the isthmus in each group. This pattern of behavior was also observed in normal adult patients¹ studied by means of computed tomography, but the relationship was always greater than 1.

The recoarctation percentages relative to surgical techniques were revised and are correct.

About the surgical indications, 79% of the patients were symptomatic. The main symptoms were heart failure with or without cyanosis in small babies (3 of them were in shock), fatigue, ache in legs, and

headache in older children. In 92 (81.4%) patients aortic coarctation was considered severe (gradient at coarctation site $\geq$ 50 mm Hg), in 12 (10.6%) patients it was moderate, and it could be not classified in 9 (8.0%) patients. Only 1 patient had infective endocarditis caused by *Staphylococcus aureus* after the operation.

The method used for spinal protection was to decrease the nasoesophageal temperature down to 33°C by means of topical pleural hypothermia. The upper limit of aortic clamping was no more than 25 minutes.

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Assessing the value of neoadjuvant chemoradiotherapy and pathologic downstaging in the treatment of non-small cell lung cancer

To the Editor:

We read with great interest the article by Machtay and colleagues,¹ which underlines the feasibility of trimodality treatment (concurrent chemoradiation followed by surgical intervention) in the cure of locally advanced non-small cell lung cancer (LA-NSCLC) and suggest the use of pathologic downstaging as a predictor for long-term survival.

Several studies have explored the combined trimodality treatment: in the ESSEN² and SWOG³ trials, patients have been treated with cisplatin plus etoposide (the same drugs used in this study for 22 patients) with a similar radiation dose (45 Gy). They reported a rate of acute toxicity similar to that reported in this article, with esophageal toxicities as the most frequent. Esophageal toxicity could correlate with the adopted radiotherapy volumes, which