coronary vein without IABP counterpulsation.

Our article¹ does not support the idea of coronary venous arterialization. We did not ligate the cardiac vein distally to isolate the arterialized venous system from the rest of the venous anatomy and to prevent steal through the coronary sinus to the right atrium, as is performed in surgical or percutaneous arterialization of the coronary venous system. However, even in the presence of the steal to the right atrium, the flow pattern of the arteriovenous graft we demonstrated may give the readers some suggestions regarding the physiology of the arterialized coronary venous system.

To be exact, the main finding of our article¹ is that it is impossible to detect incorrect grafting of the LITA to the coronary vein by flow waveform analysis with the transit time flow measurement under IABP counterpulsation.

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doi:10.1016/j.jtcvs.2004.11.008

Difficulty of early diagnosis in patients with solitary pulmonary nodule

To the Editor:

We would like to express our opinion about the article by Crestanello and associates.¹ First, we congratulate them for the well-performed study contributing to the early diagnosis of lung cancer. Because an early diagnosis is likely to lead

to better survival, it is necessary to find a useful, easy, low-cost method to obtain better survival in patients with non-small cell lung cancer. But the results of this study seem to indicate that low-dose computed tomography (CT) screening is not the gold standard to obtain an early diagnosis. Low-dose CT screening in a well-selected group of patients detects a large number of indeterminate pulmonary nodules, but the diagnosis is not always made in the early stage; 7 patients (14.5%) had advanced lung cancer in stage IIIA or greater. These patients had a late diagnosis, despite an excellent treatment algorithm and a retrospective analysis of previous thorax CT. The percentage of patients with advanced lung cancer is very high for a well-selected group of patients, how is relatively high (39%) the percentage of benign nodules submitted to surgical operation.² Discussants emphasized that the main problem remains in detecting nodules less than 1 cm in diameter, whereas fortunately no discussion is necessary on the detection of nodules larger than 2 cm.

What is meant by the authors' statement, "morphologic appearance worrisome for cancer"?

Did the authors consider ground-glass opacity or other CT pattern? In their study, did the authors investigate the presence of ground-glass opacity³ in nodules less than 1 cm in diameter? Some recent studies have established a correlation between this CT pattern and the possibility of a malignant pulmonary nodule. If they studied this pattern, was the correlation observed in 37 nodules less than 1 cm in diameter in the patients enrolled in their study?

Last, what do the authors think about a computer-aided diagnosis and serial CT scan? These 2 methods have been proposed to distinguish between benign and malignant nodules.^{4,5} The computer-aided program can predict the histology of solitary pulmonary nodules by means of a simple chest x-ray film, whereas the serial CT scan algorithm enables volumetric modeling and may permit accurate assessment of doubling time over a relatively short period (20 days).

In conclusion, we believe that low-dose CT alone is not adequate to screen for solitary pulmonary nodules because it is possible to miss an early diagnosis and

difficult to differentiate between malignant and benign nodules.

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doi:10.1016/j.jtcvs.2004.10.028

Reply to the Editor:

We appreciate Sortini and colleagues' comments concerning our report regarding surgical intervention in patients enrolled in a computed tomography (CT) screening trial. The radiographic finding in nodules that we considered worrisome for cancer include spiculation, noncalcification, diameter greater than 7 mm, and enlargement on serial examination.

The question about ground-glass opacities observed on CT is important. Our current policy is to carefully observe ground-glass opacities that are less than 7.0 mm in diameter. If they enlarge, we would either perform a percutaneous needle biopsy or thoracoscopic wedge resection of the nodule to establish a histologic diagnosis.

Our report included 16 patients in the surgical group with ground-glass opacities. Six of these patients had nodules that were