require special scrutiny: daily chest x-ray films are recommended only for patients with respiratory failure supported by mechanical ventilation or for acute cardiopulmonary problems. This does not compromise all postoperative cardiothoracic patients (http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonThoracicImaging/RoutineChestRadiographDoc7.aspx [last accessed August 2007]).

In Germany, government regulations require that each radiograph be ordered by a physician with a documented clinical indication (<http://www.bmu.de> [homepage of the German Federal Ministry for the Environment, Nature Conservation and Nuclear Safety, last accessed August 2007]). Therefore, radiologic assessment of a patient solely on a routine daily basis is actually illegal. A change in the clinical status of a patient (eg, laboratory findings, new chest tube) and a lack of alternative diagnostic tools (eg, ultrasound) have to be present before a chest radiograph is performed. This reflects the fact that any unnecessary radiation exposure should be avoided.

We hope that this study further helps to abandon the seemingly still common practice of daily routine chest radiographs.

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Reply to the Editor:

We appreciate the attention paid by Kappert, Stehr, and Matschke to our article concerning the elimination of daily routine chest radiographs in post-cardiothoracic surgery patients.¹ They raised several issues, which we would like to address point by point.

First, it may seem surprising that the ethics committee deemed it unnecessary to obtain informed consent when abolishing a daily routine strategy. However, it was in fact a medical decision to change the policy of obtaining daily routine chest radiographs in view of all the data indicating its limited value.² This study was used to evaluate the effects of that medical decision. In addition, in a separate prospective study, daily routine chest radiographs were blinded to attending physicians but evaluated by trained radiologists, that is, unsuspected predefined major abnormalities were disclosed and communicated with attending intensive care unit physicians.³ In that study, we demonstrated that the number of unsuspected predefined major abnormalities on daily routine chest radiographs was low (4.4%) and the number of radiographs resulting in a change in therapy was even lower (1.9%).

Second, we agree with Kappert, Stehr, and Matschke that the current American College of Radiology guidelines only recommend chest radiographs for patients with respiratory failure supported by mechanical ventilation or with acute cardiopulmonary problems. Indeed, this is not the case in all cardiothoracic patients.

Third, it is interesting to read that a daily routine strategy for obtaining chest radiographs is in fact prohibited by law in Germany. At least in the Netherlands, a daily routine strategy for obtaining chest radiographs in every patient in the intensive care unit is still frequently practiced,⁴ although in our experience this extends to many other countries in the world. We fully agree with Kappert, Stehr, and Matschke in hoping that this approach will change in view of all the available evidence.

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Surgery for esophageal cancer: Do age or incorrect data analysis have any impact on clinical outcome?

To the Editor:

Within the frame of a general concern about the quality of scientific articles published in peer-review international journals, I would like to make some considerations regarding the manuscript by Ruol and colleagues¹ recently published in the *Journal of Thoracic and Cardiovascular Surgery*, titled "Results of Esophagectomy for Esophageal Cancer in Elderly Patients: Age Has Little Influence on Outcome and Survival."

The authors conclude that age should not be considered a contraindication for elderly patients (>70 years) because in their retrospective study no significant survival difference was found between elderly and younger patients.

In the light of the large series described, the authors had the opportunity of providing the scientific community with a clinically relevant piece of information: unfortunately, owing to some evident limits in their data analysis, Ruol and colleagues have missed this opportunity by significantly undermining the reliability of their work.

My perplexities on this article mainly arise from the following considerations, which are mainly statistical in nature:

1. The authors state they used the Kaplan-Meier method to compute survival estimates, which is virtually the only method used worldwide to this aim. However, the curves