team approaching these cases “dares” to put it in place.

Krasna¹ comments that data “are to be taken with a grain of salt.” In our opinion, it is time for the surgical and oncologic scientific societies to open the discussion to pave the way for a meta-analysis on this topic. We do believe, in fact, that recommending a pneumonectomy after IT is an extremely delicate issue and that this decision should be supported by the most reasonable achievable base of evidence.

Giacomo Cusumano, MD
 Alfredo Cesario, MD
 Stefano Margaritora, MD
 Division of Thoracic Surgery Catholic
 University Rome
 Italy IRCCS San Raffaele Pisana
 Rome, Italy

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Reply to the Editor:

I thank Cusumano, Cesario, and Margaritora, of the Division of Thoracic Surgery, Catholic University, Rome, Italy, for their letter. I absolutely agree with them that there are cases in which pneumonectomy should be performed after induction chemoradiation therapy. It was the intent of my “counterpoint” article to identify through a review of recent articles whether there was enough evidence to state that the use of pneumonectomy in this setting was standard or not. Thus far, the number of articles supporting this approach remain outweighed by those against its use. Recently, however, several articles have appeared in the thoracic journals that *do* provide new data supporting the use of pneumonectomy in this setting.¹⁻⁴ Given these recent articles, as well as the practice of several centers in the United States and in Europe, I would agree that a meta-analysis should be undertaken. This may be difficult inasmuch as many of the articles use different end points and definitions. Rather, a combined report from several sites sharing specific variables would be a helpful first step. I for one would look forward to joining with this effort.

At the present time, despite my strong *feelings* that pneumonectomy should be done, further definition of the correct subgroup and standardization of the approach are still begging.

I applaud the group from Rome as well as their colleagues at the other two large Roman hospitals who have pursued this approach aggressively and look forward to collaborating with them.

Mark J. Krasna, MD
 Medical Director
 St Joseph Cancer Institute
 Towson, Md

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