the baseline fibrinogen concentration and decrease blood loss.

Finally, the relationship between the plasma fibrinogen concentrations, measured using either the Clauss method or maximal clot firmness measured using FIBTEM (a ROTEM assay; Tem International, Munich, Germany), and early postoperative blood loss was recently studied in the pediatric population.⁶ Plasma fibrinogen concentrations <1.5 g/L and maximal clot firmness on fib-tem <3 mm predicted postoperative blood loss with good sensitivity and specificity. Because the test is available rapidly at the bedside, the maximal clot firmness on fib-tem should be preferred to guide fibrinogen replacement. I would have been interested to read what fibrinogen level measured immediately after bypass predicted for a second administration of cryoprecipitate. Knowing this could have improved the transfusion algorithm in children undergoing cardiac surgery as suggested in Figure 1.

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CLOSING THE STABLE DOOR BEFORE THE HORSE LEAVES To the Editor:

In response to the excellent article, "Povidine iodine: The new solution for mesothelioma?" by Valerie W. Rusch,¹ indicating favorable outcomes with addition of hyperthermic povidone iodine to the multimodality approach to malignant pleural mesothelioma, it might also be considered that there are no recorded cases of mesothelioma in the medical literature after earlier pleurodesis by introduction of pleural sclerosants, including povidone iodine, to prevent recurrent pneumothorax in young men.² In view of the very large number of such individuals worldwide who have undergone this procedure during the last 70 years and universal awareness of a potential risk of inducing malignancy, it would seem reasonable to suspect that the changes these sclerosants produce in the parietal pleura may in fact prevent development of mesothelioma. If this is correct, a younger individual with evidence of asbestos-related pleural plaques might choose simple pleurodeses to remove the long-term slight but real threat of development of mesothelioma.

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COMPUTED TOMOGRAPHY OR CHEST RADIOGRAPH SURVEILLANCE FOLLOWING STAGE I NON-SMALL CELL LUNG CANCER RESECTION? To the Editor:

We read with interest the article by Crabtree and colleagues¹ about appropriate radiologic surveillance following lung resection for stage I non-small cell lung cancer (NSCLC). This issue is strictly linked with another topic: lung cancer screening. In fact, postoperative surveillance should focus not only on early detection of lung recurrences but also on new primary lung cancers.

The authors' most significant results are that in the computed tomography (CT) group, time to diagnosis of new malignancy was shorter and that 49% of patients affected by new malignancy were asymptomatic (vs 19% in the chest radiograph group). In fact, early diagnosis and symptoms absence should be correlated with more possibilities of an effective therapeutic strategy. Surprisingly, the authors found that the proportions of patients referred to curative therapy for new malignancy were the same in the 2 groups. Moreover, overall survival in patients developing successive malignancy were not associated with radiologic surveillance. These data could suggest that CT, although associated with some advantages, has the same outcomes as chest radiograph in surveillance of patients submitted to lung resection for stage I NSCLC. Moreover, these results are inconsistent with the National Lung Screening Trial, which showed in a larger population