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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<http://dx.doi.org/10.1016/j.jtcvs.2015.01.053>

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

that CT in high-risk subjects guarantees better overall and cancer-specific survival than chest radiograph.

Should we adopt chest radiography? Probably not, considering that, as suggested by Crabtree and colleagues,¹ results could have been influenced by sample size. Also, in the CT group 20% of patients underwent subanatomic resection, whereas in the chest radiograph group this was required in only 8%. It is common opinion² that in stage I NSCLC populations, although sublobar resection is considered successful, wedge resection is associated with lower survival and higher recurrence rate than anatomic resection. This bias could have influenced results. Another bias could be represented by the technique adopted for lymphadenectomy. Unfortunately, the authors do not report if they performed sampling or systemic dissection in every patients. In fact, we know that when lymphadenectomy is incomplete, it may lead to N downstaging and influence survival.³

Without any prospective data supporting chest radiograph surveillance, we think that CT follow-up should be always adopted, but further study to determine the best type of CT scan and its timing should be encouraged.

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MALIGNANT PERICARDIAL EFFUSION: DIFFERENT THERAPEUTIC PERSPECTIVES To the Editor:

We read with great pleasure the manuscript by Celik and colleagues.¹ The treatment of malignant pericardial effusions remains largely empirical because of the lack of large randomized control studies to determine the optimal treatment regimen for these conditions. In a large study, Celik and colleagues¹ commendably compared 3 different treatment modalities for malignant pericardial effusions: systemic chemotherapy plus pericardial window versus systemic chemotherapy alone versus systemic chemotherapy plus drainage. The efficacy of 2 alternate effective treatment modalities, however, namely percutaneous balloon pericardiotomy (PBP) and pericardiocentesis with prolonged catheter drainage, were not specifically evaluated in this study.

There is significant evidence to suggest that patients with recurrent symptomatic pericardial effusions secondary to malignant disease can be successfully treated with PBP, which is a minimally invasive procedure. Some experts suggest its use as an initial and definitive treatment modality for treating malignant pericardial effusions, especially in patients with advanced oncologic disease with predictably limited survival to relieve their symptoms and improve their quality of life.² PBP creates a direct pleuropericardial communication and is an alternative to creating a subxiphoid surgical window. It successfully prevents recurrent effusions in more than 80% of the cases³ and seems to be about 90% to 97% effective for large malignant pericardial effusions.⁴

Patients with pericardial malignancies are also prone toward the development of large and tamponading pericardial effusions, and PBP has been successfully used for relieving tamponade in such patients as well.⁵

Celik and colleagues¹ evaluated the role of pericardiocentesis, although it is unclear how many patients received extended or prolonged catheter drainage. A recent large study compared surgical pericardiotomy with “pericardiocentesis plus prolonged catheter drainage” in patients with symptomatic malignant pericardial effusions and found prolonged drainage to be a safe and effective treatment modality with a significantly lower rate of complications than surgical pericardiotomy.⁶ It can especially avoid the surgical risk and discomfort in patients with advanced pleuropericardial malignancies, and thus it may be a particularly better therapeutic option for patients with limited expected survival.^{6,7}

The treatment of malignant pericardial effusions often poses a challenge, and clinicians should thus be aware of these less invasive alternative treatment options, especially for patients with advanced malignancies and when the overall treatment goal is palliative care.

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