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, 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 opinion 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 systematic dissection in every patients. In fact, we know that when lymphadenectomy is incomplete, it may lead to N downstaging and influence survival.

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.

References

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MALIGNANT PERICARDIAL EFFUSION: DIFFERENT THERAPEUTIC PERSPECTIVES To the Editor:

We read with great pleasure the manuscript by Celik and colleagues. 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 colleagues 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 pericardiectomy (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. 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 cases and seems to be about 90% to 97% effective for large malignant pericardial effusions. 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.

Celik and colleagues evaluated the role of pericardiocentesis, although it is unclear how many patients received extended or prolonged catheter drainage. A recent large study compared surgical pericardiectomy 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 pericardiectomy. 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. 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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Notices of Correction


In the full-text online version of the article, Figures 2 and 3 are switched. Readers should refer to the PDF or print version of the article, which are both correct.


In the above-mentioned article, Table 1 contained errors in the “Overall” column for the rows “Late mortality,” “Interstage death (1 → 2),” and “Interstage death (2 → 3).” The entries should be as follows: Late mortality, 14 (13.1%); Interstage death (1 → 2), 4 (3.7%); and Interstage death (2 → 3), 6 (5.6%). The corrected table is reprinted on the next page.