We are pleased that Pankaj Kumar Mishra has read our article and taken the time to react to it. We agree that the study could have been made as he suggests including four to five different interviewers making pre- and post-operative face-to-face interviews with 341 patients living in a wide area in southern Sweden. However, we had to plan the study from a perspective where the clinical and the economic realities are taken into consideration. The method used in our study is an accepted and well-documented scientific method also used for subjective measures.

In Sweden, patients do not sign any consent forms before surgery. Before the patients are enrolled in any waiting list, they do not meet a surgeon and most often do not get any surgical information. In most cases, the patients only meet the surgeon when they are admitted to the hospital. The patients in our study got the pre-operative information at the same time as the questionnaire, i.e., they had a possibility to be well informed when they answered the questionnaire.

Mishra thinks that the demographic data are not sufficient to measure the intelligence of the patients included in our study. Our aim was not to measure the intelligence. The patients in the study were not selected at all. The extended information was written so that most persons, independent of IQ, should be able to understand it. One limitation with our study was that the written extended information was not adapted for minority groups, such as persons with dyslexia or visual handicaps. Ideally, the information to patients should be transmitted in different types of media, e.g., brochures, video-tapes, talking-brochures, interactive web-pages, and so on, each in different comprehensive levels. Thus, extended information becomes a good and useful starting point for fruitful conversations between the healthcare personnel and the patient. Moreover, it can hopefully help patients with high, medium or low IQ, to search for more information. When the patient meets the surgeon he/she has the possibility to be well prepared.

As pointed out in our article, patients could not be randomised for practical reasons, including the risk for leakage of information between the groups.

**References**


My coauthors and I thank Altundag et al.’s suggestions on our report [1]. Although no patient had received adjuvant chemotherapy in a prescribed fashion in our 40 completely resected elderly cases, we recognize the value of post-operative chemotherapy. A role of single-agent therapy with uracil-tegafur or cisplatin-based adjuvant chemotherapy in patients with resected stage IB or stage II non-small cell lung cancer has come under review in recent years [2,3]. Elderly patients are often considered incapable of tolerating platinum-based systemic chemotherapy. But Langer and coauthors reported that response rate, toxicity, and survival in elderly non-small cell lung cancer patients receiving platinum-based treatment appeared to be similar to those in younger patients, although patients 70 years old or older had more comorbidities and could expect more leukopenia and neuropsychiatric toxicity [4]. Vinorelbine represents a well-tolerated treatment for elderly patients with advanced non-small cell lung cancer. It improved survival of elderly patients with advanced non-small cell lung cancer and had possibility to improve overall quality of life [5]. Advantage of these agents as adjuvant chemotherapy for elderly patients needs to be verified in prospective randomized studies. We think that advanced age alone should not preclude appropriate non-small cell lung cancer treatment.

References