and tumour stage of TENs. Nevertheless, the ability to interpret the literature becomes vitiated without a deeper statistical analysis that could shed some light onto a widely used statistical procedure known as correlation analysis [4]. Based on the findings reported in the previous studies on haematological neoplasms [5], the determination of metabolic tumour volume as a volumetric parameter of 18F-FDG PET/CT could be, in future, an important independent factor for the preoperative evaluation of TENs. A new prognostic stratification based on the WHO stage or Masaoka staging system, and the volumetric parameter of 18F-FDG PET/CT might help optimize patient care by providing better prognostic information. Additional prospective studies with larger numbers of patients are needed to validate the prognostic utility of this promising functional biomarker derived from 18F-FDG PET/CT.

**REFERENCES**


**LETTER TO THE EDITOR RESPONSE**

**Reply to Bertolaccini et al.**

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**Keywords:** 18F-FDG PET-CT • SUVmax • Thymic epithelial tumours • Histologic type • Stage

We thank Bertolaccini et al. [1] for their interest in our paper [2] and appreciate the opportunity to reply. To begin with, we would like to point out some misunderstandings with regard to our paper. In our analysis, we divided 58 patients with thymic epithelial tumours into three groups according to a simplified histological classification: low-risk thymomas (Types A, AB and B1, n = 23), high-risk thymomas (Types B2 and B3, n = 21) and thymic carcinomas (n = 14). The maximum standardized uptake value (SUVmax) of the thymic carcinomas was significantly higher than those of the low-risk and high-risk thymomas (P < 0.001, respectively). No significant differences were observed between the low-risk thymomas and the high-risk thymomas (P = 0.204). In addition, as shown in Figure 3 in our article, the SUVmax of the Stages III and IV thymomas showed a higher trend towards Stages I and II thymomas (P = 0.060). We excluded thymic carcinoma cases in this analysis because the majority of them were in advanced stages. Although no significant differences were observed between the low-risk and the high-risk thymomas, we suppose that significant differences might appear if the number of patients increases. We think that the large confidence interval in our box–whisker plot is due to the small number of cases.

As often said, SUVmax is a very nonuniform value between institutions. It depends on the dose of radionucleotide that is given, the machine, the timing of scanning and the radiologist reading it and so on. Calculating the SUV tumour mediastinum (T/M) ratio is one of the methods to ensure the universality of SUVmax in [18F] fluoro-2-deoxy-D-glucose positron emission tomography-computed tomography [18F-FDG PET-CT] [1]. We cannot provide these data in our cohort, as they were not available in our previous cases. However, as other authors have demonstrated [3–5], there is little difference between the results of SUVmax T/M ratio and nonadjusted SUVmax. We believe that nonadjusted SUVmax in 18F-FDG PET-CT can play an important role in the differential diagnosis between thymomas and thymic carcinomas. The area under the curve in receiver-operating curve for the differential diagnosis between thymomas and thymic carcinomas was 0.951 in our cohort (data is not shown), a result that is considered to be quite good.

We completely agree on the necessity of prospective studies with a larger number of patients, as thymic epithelial tumours are quite a rare disease. Discussions between not only thoracic surgeons, but also radiologists and pathologists are required to ensure the universality of radiological and pathological diagnoses.
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LETTER TO THE EDITOR

Lungs from donation after cardiac death for transplantation

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Keywords: Lung transplantation • Donation after cardiac death

We read with interest the publication by Zych et al. [1] regarding lung transplantation from donation after cardiac death (DCD) donors. Concern that DCD lungs might be inferior to lungs from brain-dead donors appear to be significant barriers to widespread adoption. Our prior studies [2, 3], which also represent a large portion of the national DCD lung transplantation experience, have been very favourable, and we advocate its utilization as a means of overcoming the donor shortage. We have approached selection, procurement and implantation of DCD organs in a fashion analogous to that for brain-dead donors with essentially no modification of our standardized protocols.

There have been concerns about the timing and dosage of heparin for DCD lung harvest. Delayed heparin administration after cardiac death does not seem to affect thrombus formation in an animal model of lung procurement after cardiac death, and concerns about thrombosis appear unfounded [4]. We noted that the authors did not administer heparin prior to cardiac arrest. However, at this juncture, we routinely administer full-dose heparin prior to a withdrawal of support and hope to expand the pool to include donors in whom heparin is not permitted.

We noticed that the authors had a higher primary graft dysfunction (PGD) 3 score on arrival to the intensive care unit in the DCD group, whereas in our series 91% of patients had PGD scores of 0 at T0, T24, T48 and T72 h. The survival in our series was 97% at 30 days, 91% at 1 and 2 years, respectively, and 71% at 3 and 4 years, and our growing experience suggests that recipient survival and early graft function using DCD lungs are excellent. Concerns about diminished organ quality are unwarranted, and the use of DCD lungs should be expanded. We whole-heartedly agree with the authors that DCD lungs are a valuable and excellent source of good quality organs for transplantation.

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