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Letters to the Editor

Capillary versus arterial blood glucose testing in the operating room

To the Editor:

The recent report on capillary versus arterial blood glucose testing in the operating room is quite interesting. Akinbami et al[1] concluded that "glucose monitoring in the operating room can be safely performed by collecting capillary samples for point of care testing (POCT)." Indeed, this correlation does not mean that one test can be used instead of the other test. As Akinbami et al noted, the confirmation is required in some situations. Indeed, using POCT glucose monitoring has many considerations. First, the standard maintenance and quality control are still required. This issue should not be overlooked. Second, the difference among the resulted capillary and arterial blood glucose test has to be kept in mind by the physician in charge. The increased variability of results from capillary sample analysis is the reason Peterson et al[2] did not recommend using it in the critical care unit. Finally, the variation among different POCT glucometers is reported[3]; hence, it is required to regularly validate the analyzer.

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Lysosomal-associated transmembrane protein 4 beta and its association with systemic carcinogenesis

To the Editor:

I read with great interest the recent article by Kang et al.[1] Lysosomal-associated transmembrane protein 4 beta (*LAPTM4B*) overexpression may be associated with a number of systemic malignancies.

In colorectal carcinomas, *LAPTM4B* is an independent indicator of tumor prognosis. For instance the 5-year disease-free survival rate is 91.8% in patients with colorectal carcinoma and low *LAPTM4B* expression in comparison with 21.2% in patients with high *LAPTM4B* expression.[2] The specificity of *LAPTM4B* overexpression in colorectal carcinomas is 100%, whereas the sensitivity is 62.5%. *LAPTM4B*2* overexpression also augments the risk of gastric malignancies developing. For instance, in a recent study the risk of gastric carcinoma developing was almost 2.4 times higher in those with the **2/2* genotype compared with those with the **1/1* genotype.[3]

Similarly, in individuals with hepatocellular carcinomas, the presence of *LAPTM4B*2* usually points toward a poor clinical outcome after resection of the hepatic malignancy.[4] In fact, the *LAPTM4B* genotype is an independent indicator of disease-free survival. Similarly, individuals with *LAPTM4B*2* are at a higher risk of the development of gallbladder carcinomas. In fact, nearly 38% of gallbladder carcinomas are positive for *LAPTM4B*2*.[5] *LAPTM4B-35* may also account for resistance to chemotherapy in gallbladder carcinomas. It augments chemoresistance by mitigating apoptosis induced by agents such as epirubicin through mitochondria-dependent pathways.[6]

An increased risk of breast malignancies developing is seen in patients who express *LAPTM4B*2*. In fact,