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. 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. did not recommend using it in the critical care unit. Finally, the variation among different POCT glucometers is reported; hence, it is required to regularly validate the analyzer.

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References


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. 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. 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. Similarly, in individuals with hepatocellular carcinomas, the presence of LAPTM4B*2 usually points toward a poor clinical outcome after resection of the hepatic malignancy. 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. 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.

An increased risk of breast malignancies developing is seen in patients who express LAPTM4B*2. In fact,
LAPTM4B*2 overexpression is associated with a poor response to chemotherapeutic agents such as anthracyclines.\textsuperscript{7} LAPTM4B*2 overexpression is also associated with an increased risk of metastatic recurrence in breast carcinomas. Similarly, LAPTM4B*2 increases the genetic susceptibility to cervical carcinomas. This is especially true in certain Asian populations, such as the Chinese population. The genetic susceptibility is greater in multiparous women as well as in those with a history of current or past smoking. In fact, Meng et al\textsuperscript{8} reported an odds ratio of 2.12 for the LAPTM4B*2/2 genotype.

The preceding examples clearly illustrate the close relationship between LAPTM4B expression and systemic carcinogenesis.

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References


Occurrence of seroma after mastectomy: where is the solution?

To the Editor:

We read the article titled “Preventing Seroma Formation After Axillary Dissection for Breast Cancer: A Randomized Clinical Trial” by Iovino et al\textsuperscript{1} with great interest. The authors need to be congratulated for addressing the issue of seroma formation after mastectomy and axillary dissection, which has been consistently a baffling problem in breast surgery. The basic essence of any randomized controlled trial is that the 2 groups (the control vs the intervention group) should be similar in all respects except the variable outcomes to be measured. There are a number of preoperative patient characteristics including the presence of underlying comorbidities (ie, hypertension), surgical factors (ie, the extent of mastectomy and suture flap fixation), and postoperative factors (ie, compression dressing, intensity of suction pressure, immobilization of the shoulder, and timing of shoulder movement) that were not commented on by the authors when comparing the 2 groups.\textsuperscript{2,3} These patient characteristics might have made the 2 groups dissimilar and might have influenced the results.

The authors compared the clinical parameters in the 2 groups using both the t test and the Wilcoxon signed rank test and provided P values in Table 2.\textsuperscript{4} It is worth mentioning here that continuous outcome variables can be compared using parametric tests (ie, the 1-sample t test and the paired t test) only when normality (and homogeneity of variance) assumptions are satisfied; otherwise, an equivalent nonparametric test (ie, the Mann Whitney U test or the Wilcoxon signed rank test) should be used.\textsuperscript{4}

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