Letter to the Editor

Resection of locally advanced thymic carcinoid tumors

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We read with interest the article by Dr. Sakuragi and colleagues concerning the iterative resection of recurrent thymic carcinoid [1]. I agree with the conclusion of the authors that aggressive surgical resection of such a neoplasm improves survival.

This is an uncommon disease, and there is no sufficient experience in the English-language literature about the ‘ideal’ treatment. Due to its indolent growth, the diagnosis is often performed when the neoplasm is huge, infiltrating the surrounding mediastinal organs with metastases to mediastinal lymph nodes. Adjuvant chemotherapy and radiotherapy have not proven to be of benefit [2] and complete extended surgical resection is, at present, the only curative treatment.

In our recent experience, two male patients underwent extended resection for giant thymic carcinoid tumors infiltrating mediastinal and pulmonary structures. Both patients underwent preoperative chemotherapy for three cycles (ifosfamide, carboplatinum and etoposide in the first patient and cisplatin, epirubicin and cyclophosphamide in the second one) without any radiologic response at the CT thoracic scan. Surgery was performed in the first patient en bloc with pericardium, left phrenic nerve, a wedge resection of the left lung, and the resection of the superior vena cava without cardiopulmonary bypass; the vessel was subsequently replaced by a ringed polytetrafluoroethylene prosthesis. The resection was complete but extensive mediastinal lymph node involvement was observed (20/29). The patient is alive without evidence of disease at 28 months after surgery. The second patient underwent dissection of the tumor en bloc with the left phrenic nerve, pericardium, and a wedge resection of the left lung. The resection was complete but even in this case, there was an important involvement of the mediastinal lymph nodes (28/28). During follow-up he developed adrenal gland metastases that was successfully resected. The patient is alive without evidence of disease 36 months after primary surgery. Both patients underwent postoperative radiotherapy.

These two cases were treated with the same therapeutic schedule (induction chemotherapy, extended surgery, and postoperative radiotherapy). Lesson learned: induction chemotherapy is useless, while aggressive surgery, when possible, is the best therapeutic option in these patients and it should be associated with extensive mediastinal lymph node dissection.

Finally, repeat surgical resection of recurrent mediastinal disease [1] or of extrathoracic deposit should be recommended and it might improve prognosis.

References


Reply to the Letter to the Editor

Reply to Spaggiari et al.

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The author would like to thank Spaggiari and coworkers for their comments regarding their experience with induction chemotherapy for this rare disease. Indeed, there is very little evidence of the strategy in the worldwide literature. I strongly support their opinions regarding treatment of this tumor.

We have a positive impression of chemotherapy and radiotherapy in the control of this tumor. In our case [1],