Bronchioloalveolar carcinoma: myths and realities in the surgical management

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The review article, ‘Bronchioloalveolar carcinoma: myths and realities in the surgical management’ by Barlesi et al. [1] was both a timely and important review of a disease whose recent changes in pathologic definition, increasing incidence and new therapeutic options will likely alter therapy at several levels. However, I would like to raise two issues.

First, the discussion of lung transplantation reports a total of 20 patients currently in the literature. However, the two series by Garver and by Zorn report on the same patients, the former in a discussion of the molecular characteristics of recurrence, the latter, on overall outcome. The second report at a later date apparently provided updated patient data accounting for the differences in the ages of the patients. Therefore, a total of 13 patients have been reported. Still, from the available data, lung transplant might remain a therapeutic consideration.

Second, the option of a lesser (wedge or segmentectomy) resection should not be totally dismissed in this disease that has a propensity for multifocal recurrence. Several publications from investigators in Japan have suggested that lesser resections in carefully selected patients offer the optimal option of survival with the minimal loss of lung parenchyma [2]. The series by Miller et al. cited in the article included only 19 patients with bronchioloalveolar carcinoma (BAC) of their total of 100 patients. They do not specify that the pathology was reviewed to confirm pure BAC (a non-invasive malignancy by the 1999 World Health Organization guidelines) [3]. One recent report noted that only 47% of previously classified BAC’s were reclassified as pure BAC on review [4]. Miller also did not report the recurrence rates in the subset of patients with BAC. They note only that histology did not independently affect survival.

By restricting lesser resections to pure ground glass opacities (with no solid component radiographically) of diameters less than 1 cm, the likelihood of finding an invasive carcinoma in what was thought to be BAC appears to be less than 10% [2]. For tumors of that size, the likelihood of nodal metastases is also small (7% in the series by Miller et al.) making the probability of performing a suboptimal operation increasingly small. This level of uncertainty is quite in line with what is accepted in low risk malignant colon polyps for which colonoscopic polypectomy is accepted as definitive therapy [5].

This approach cannot be recommended yet in larger BAC’s. Even in the smaller lesions, the follow-up time in the lesser resection series noted above is short, and long-term results and optimally randomized trials are needed to confirm the appropriateness of a lesser procedure. However, the acceptability of selective and careful application today and the possibility that it might become standard of care in the future should be considered.

References


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