Letter to the Editor

Surgery for T4 non-small cell lung cancer

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We read with interest the recent article [1] in the journal on surgical resection of T4 non-small cell lung cancer (NSCLC). We agree with Pitz et al. that T4 tumors are a heterogeneous group of tumors and need to be treated on an individual basis. Thoracic surgeons and oncologists should understand that not all T4 tumors are to be considered similar to the clearly more advanced N3 disease (both stage III B) and treated with palliative intent.

However, we feel that the article should have emphasized that the 89 patients considered in the study constitute a highly selected group. Rather than the 2009 consecutive patients with NSCLC treated with surgical resection in the department, a more valid statistic would be the total number of T4 NSCLC patients who presented to the department over the same timeframe. This would give a realistic estimate of the small proportion of patients with T4 tumors who can be considered for surgical resection. The key message of the article should not be that T4 tumors are resectable and have a reasonable long-term survival, but that among carefully selected patients (preferably with the broad selection criteria specified), long-term survival is possible.

We disagree with the authors when they advocate a metastatic workup only in patients with symptoms of metastases. Patients with T4 tumors have a relatively high incidence of occult metastases and warrant a complete metastatic workup if they are being considered for curative surgery. This is in contradistinction to patients with T4 tumors being considered only for palliative treatment wherein the metastatic workup would clearly be dictated by the patient’s symptoms. Surgery in patients with locally advanced T4 tumors is a not-inconsiderable exercise and these patients should have rigorous screening for distant metastases (including PET-CT, where available) to rule out M1 disease. Operating on patients with occult M1 disease would unfairly negate the positive results of surgical resection.

Considering the long-term results quoted in the study, we wonder why the postoperative deaths were excluded from the 5-year survival figures. This gives an unduly optimistic estimate of outcome after surgical treatment of an advanced cancer. We believe that the overall 5-year survival figures given should also take treatment (surgery)-related deaths into consideration. Incidentally, the better survival seen in patients with N2 disease (better than N0 and N1) appears to be a chance finding given the small number of patients.

We agree with the authors that multimodality treatment regimes may improve the overall outcome in these patients. Our own approach in patients with T4 tumors with a good performance status is to treat them primarily with neoadjuvant chemotherapy. Patients who respond to chemotherapy and who have resectable tumors are offered surgery whereas others are treated with radiotherapy. In summary, the authors deserve to be congratulated on bringing out an important message that not all patients with T4 tumors warrant a nihilistic therapeutic approach.

Reference


* The authors of the original paper [1] were invited to comment on this Letter to the Editor but declined the offer.

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Letter to the Editor

Coronary artery tourniquet and shunting: acute effects and wall damage

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