Letter to the Editor

Pulmonary resections for T4 non-small cell lung cancer with support of cardiopulmonary bypass

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We read with much interest the article 'Extended pulmonary resections of advanced thoracic malignancies with support of cardiopulmonary bypass' by Wiebe et al. [1]. The authors presented in an exciting way their experience with extremely difficult surgical treatment of the pulmonary malignancies infiltrating the heart or great vessels. Such kind of surgery obviously deserves the highest level of expertise. The authors are especially congratulated for the results of treatment of sarcomas which are known for the resistance for chemotherapy and radiotherapy, the radical operation being the only curative solution in these patients. The 5-year survival of 62.5% in this group may indicate the way that kind of tumor should be managed more often in the future.

Our concern, however, is the management of patients with advanced non-small cell lung cancer. There were three patients in the presented group, all of them T4, according to Table 2. In such group the rate of N2 involvement is very high, so the need for the thorough mediastinal staging is generally agreed upon. The authors state that all patients with NSCLC underwent cervical mediastinoscopy. This is surprising that the tracheal infiltration by pT2 nodes, which ought to have been easily discovered during mediastinoscopy, was unexpectedly found during the operation. As the authors wrote that one-third patients underwent neoadjuvant chemotherapy and radiotherapy, it would be very interesting to know what was the method of restaging in this patient. It would also be interesting to know if N2 disease was excluded during mediastinoscopy in the other two patients.

The indications for use of CPB in three patients with NSCLC were emergent in one patient and unexpected in two patients. In these patients there was an infiltration of the main pulmonary trunk (patient 2), left atrium (patient 4) and the pulmonary trunk and descending aorta (patient 13). Therefore, this extensive infiltration was not correctly estimated preoperatively. Such diagnostic inaccuracies may of course happen, despite the availability of advanced diagnostic modalities, however the patients with sarcomas operated on by the authors, with similarly advanced tumors were diagnosed much more accurately and operated on in the planned way. There is no mention about intraoperative staging being currently regarded as a standard of radical surgery in lung cancer. Again, it would be interesting to know if the authors performed any kind of lymphadenectomy or nodal sampling and if they found any N2 or N3 nodes intraoperatively. Contrary to the excellent results achieved in sarcomas, the results in NSCLC are quite discouraging with no 3-year survivals. There was no mention if any kind of adjuvant treatment was considered in these patients. In our opinion, the conclusions of the study strongly support further attempts of extended resections in sarcomas with use of CPB; however, such method of treatment of NSCLC remains highly controversial.

References


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Reply to the Letter to the Editor

Reply to Zielinski and Kuzdzal

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The main concern of Zielinski and Kuzdzal [1] is a crucial issue. Due to a lack of evidence there is no firm guideline for...