Letter to the Editor

Sleeve lobectomy.

Is it valid for all cases of lung cancer?

Mohamed Ismail*
Mansoura University Hospitals, Mansoura, Egypt

Received 15 February 2007; accepted 15 March 2007; Available online 20 April 2007

Keywords: Sleeve lobectomy; Bronchogenic carcinoma; Pneumonectomy

I read with interest the article by Yildizeli [1] but would like to make some comments about it.

1. The first sleeve lobectomy for a bronchogenic carcinoma was done in 1952 and not 1954 as mentioned by Allison [2–4].
2. It was mentioned that bone scanning was performed in symptomatic patients or in patients with abnormal blood work which may lead to many missed metastatic bone lesions.
3. They discussed that surgicopathologic staging was performed according to the New International Staging System for Lung Cancer (International Union Against Cancer, 1997) [1]. I would like to get clarification on the old cases which were collected since 1981 and their method for staging. Was the staging based on the recent or older cases?
4. Among the cases of this study, there were five patients who had a history of lobectomy for contralateral lung cancer [1]. Was the new ipsilateral lung cancer metastatic lung cancer or second primary?
5. One of the stage I patients had a synchronous contralateral stage II lung cancer for which a lobectomy was performed 6 weeks later [1]. I wonder if this patient should have been scheduled as stage I, or transferred to stage IV as the contralateral lung cancer should be considered as distant metastasis [5].
6. Because closing the main bronchus ostium at the level of the carina produces excessive suture tension, the sleeve lobectomy performed in these 15 patients can be considered an alternative to sleeve pneumonectomy [1]. A more detailed explanation is needed as I didn’t know if the anastomosis had been done to the carina, or if the right carina was closed then another opening at the tracheobronchial junction was used for the anastomosis with the bronchus intermedius. As we know, sleeve pneumonectomy depends on total excision of the carina with the removed lung and reanastomosis of the trachea to the main bronchus of the remaining lung.
7. Resection was incomplete in nine (4.1%) patients in whom frozen sections of the bronchial margin were positive but pneumonectomy was contraindicated by the results of preoperative investigations [1]. These patients with contraindication for pneumonectomy regarding the pulmonary functions or any other causes were in need of other modalities such as neoadjuvant therapy or multimodality therapy. I do not think the decision for surgery in these patients was right from the start. The collected risk factors in that article [1] are supporting my opinion as there was no improvement of survival in advanced stages even with sleeve surgery. Therefore it is wise to have the other lines of management instead of exposing the patient to the risk of surgery and repair of positive margins.

Finally, I want to thank the authors for their great work for collecting this data and publishing this informative article.

References


* Corresponding author. Address: 71 El-sedek st., Ahmed Maher st., Mansoura, Egypt. Tel.: +20 50 2266741; fax: +20 50 2234111.
E-mail address: mfismail2299@yahoo.com.

doi:10.1016/j.ejcts.2007.03.025

Reply to the Letter to the Editor

Reply to Ismail.

Sleeve lobectomy for lung cancer

Bedrettin Yildizeli*, Elie Fadel, Philippe G. Dartevelle
Department of Thoracic and Vascular Surgery and Heart-Lung Transplantation,
Hôpital Marie-Lannelongue,
Paris-Sud University, Le Plessis Robinson, France

Received 13 March 2007; accepted 15 March 2007; Available online 24 April 2007

Keywords: Sleeve lobectomy; Bronchoplastic resection; Lung cancer; Complications; Survival

We appreciate the comments of Dr Ismail [1] regarding our study. In response, there are a few clarifications to be made. If history, physical examination, and initial laboratory screening results are negative, the likelihood of finding metastatic disease on subsequent staging procedures for the patients with lung cancer is low. According to American College of Chest Physicians evidence-based guidelines (1997), patients with clinical stage I and II lung cancer and normal results of a clinical evaluation require no further imaging for detection of extrathoracic disease. Therefore, we perform bone scanning in symptomatic patients or in patients with abnormal blood work. On the other hand, the use of positron emission tomography (PET) in the evaluation and management of patients with malignancy continues to increases. Since PET has similar sensitivity, although poorer specificity, when compared with the isotope bone scan [2], we do not need to perform any further investigations for patients who have negative PET scan.