Letter to the Editor

Pulmonary metastasis resection: is it a question of optimal timing or tumor doubling time?

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The recent article titled “The optimal timing to resect pulmonary metastasis” [1] arouses some questions. Management of pulmonary metastasis (PM) is certainly challenging and I agree with authors that standardization is needed for surgical indications.

In a multivariate analysis, the interval from PM detection to resection, and the interval from PM resection until recurrence were significant independent prognostic factors. Then the authors made two groups of patients: those who relapsed within 1 year after PM resection (group A), vs those who did not (group B). Finally, a comparison of mean interval from PM detection to resection between the two groups shows a significant difference: 2.9 months in group A vs 7.1 months in group B, p = 0.003. Authors conclude that performing metastasectomy at least 3 months after detection of PM may significantly improve the prognosis of patients.

In the study, the population of patients has more than 12 different metastatic histologies: colorectal, kidney, lung, esophagus, breast, etc. Thus, a major statistical bias clearly appears here: the population is not homogenous, and comparable groups cannot be created. Another bias is in the discussion; the exclusive reference in the literature appears here: the population is not homogenous, and comparable groups cannot be created. Another bias is in the discussion; the exclusive reference in the literature consistent with their results is a previous study reported by our authors.

Here are the reasons why I do not share the conclusion of Tanaka et al. In fact, the authors have approached the well known topic that patients with short tumor doubling time (TDT) have worse outcomes than patients with a long TDT in pulmonary metastatic disease [2]. TDT in pulmonary metastasis recently caused new interest, since as demonstrated by Tomimaru et al., it is an independent predictor of intrapulmonary recurrence after pulmonary resection of solitary pulmonary metastasis [3].

Mean metastatic TDT is known to be faster than primary tumor TDT. But contrary to primary tumors [4], survival-related TDT in pulmonary metastasis has not been analyzed by histological sub-groups.

In conclusion, taking into account histology of primary tumor and tumor doubling time appears to be crucial in management of pulmonary metastasis. We will in further randomized and prospective studies have to answer questions such as ‘does it make sense to remove a short-TDT pulmonary metastasis?’

References


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Reply to the Letter to the Editor

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We would like to thank Dr Pagés for his helpful comment [1] on our study [2]. In this study, some limitations remained as you pointed out. Further investigation will provide answers to the questions. This time, we did not refer the impact of tumor doubling time (TDT) on the outcome after metastasectomy, because we did not have analyzable data about it. However, we also got the impression that short TDT was the sign of uncontrollable disease. I guess the period of careful observation is necessary before metastasectomy to assess such important factors. Anyway, we need further studies to standardize the indication of lung metastasectomy.

References


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