Letter to the Editor

The emerging role for combined endosonography with fine needle aspiration in lung cancer staging: is the scope the right one?∗

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We have read with interest the article by Szlubowski et al. in the journal [1] reporting that trans-oesophageal endoscopic ultrasound with fine needle aspiration (EUS–FNA) combined with endobronchial ultrasound with trans-bronchial needle aspiration (EBUS–TBNA) — or in short, CUS–NA — has a sensitivity of 68% to detect malignant mediastinal lymph nodes in patients with cIA–IIB non-small-cell lung cancer (NSCLC). These data are important and will help to further delineate an optimal preoperative mediastinal staging strategy in resectable NSCLC.

The selection of the right investigation(s) for the right patient remains a challenge in NSCLC patients in whom the mediastinum needs to be investigated. The definition of a ‘radiologically normal mediastinum’ is, however, not actual anymore to categorise patients for a subsequent procedure. This strategy is jeopardising the clinical meaning of the current data as presented.

The reason is that patients with IA–IIB NSCLC represent a heterogeneous population with different prevalences of nodal invasion. Patients with a stage IA peripheral NSCLC have a prevalence of N2 metastasis of 9% overall, and less than 6% if an 18-fluoro-deoxy-D-glucose–positron emission tomography (FDG–PET) scan is negative, explaining why the guidelines do not recommend invasive mediastinal staging in this subgroup [2,3]. Patients with centrally located N0 NSCLC or with clinical N1 NSCLC have a much higher prevalence — up to 30% — of mediastinal metastasis [2,4]. A more relevant definition would have been to select patients with normal-sized but clinically suspect mediastinal lymph nodes. For example, it has been shown that for patients with small (<10 mm short axis), but suspect lymph nodes (based on FDG uptake in the mediastinal nodes, or because of enlarged or FDG hot hilar nodes) or because of a centrally located lung cancer; the sensitivity of EUS–FNA is as high as for enlarged mediastinal nodes [5]. Since the ‘pre-test probability’ is the strongest determinant for investigations’ test characteristics, it would be very informative for the reader if the authors provide more data on the distribution of T and N descriptors and on the clinical suspicion for nodal invasion on the one hand, and the relation to the performance of CUS–NA on the other hand.

Besides that, the authors mention CUS–NA was false positive in two patients. Although this influences the specificity and positive predictive value, the data seem contradictory with the methods section indicating that only negative CUS–NA findings were verified by surgery. It is important to stress that values regarding positive predictive value and specificity are only reliable if these have been measured systematically in all patients, and if the data are not based on an occasional finding. Since false-positive findings are extremely important, the authors should provide more details regarding how these were obtained and how these data should be interpreted.

Despite these flaws, this is an important study and a welcome addition to our knowledge base. The authors are to be commended for their work.

References


∗ The authors of the original paper [1] were invited to reply to this Letter to the Editor but they did not respond.
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