Is limited surgery recommended if nodal involvement cannot be ruled out?

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We have read with interest the paper by Hattori et al. [1] about appropriate surgical strategy for sub-centimetre solid lung cancer. Indications for limited surgery of <1 cm tumours have become of greater concern in thoracic surgery, but, to date, there has been no definitive answer on the proper parenchymal resection extension (lobar, sub-lobar, nonanatomical) and on the correct nodal management (single biopsy, sampling, complete dissection). The authors have correctly distinguished <1 cm tumours in solid and non-solid nodules, and focused their attention on solid tumours (both part-solid and pure-solid). Their results are interesting since they have statistically determined that, even in case of <1 cm nodules, nodal metastases are frequently observed if the tumour has a pure-solid appearance and SUVmax > 2.5. These two factors also predicted survival. However, we have many concerns regarding the material and methods and, the conclusions.

Patients in both pure-solid and part-solid nodule groups underwent different kinds of surgical resection (lobectomy, segmentectomy or wedge resection) but the criteria adopted to determine surgical strategy are not reported. The authors only report that all patients had cNO lung cancer. We think that such a dishomogeneous population could be a relevant bias in determining survival.

Also regarding nodal staging management, patients enrolled underwent very different procedures. In fact, some of those underwent complete dissection or nodal sampling, and, more surprisingly, 31% of candidates did not receive any nodal biopsy at all. The authors reported that, in some cases, this surgical strategy was determined by the patients’ poor general conditions. In our opinion, these criteria affect parenchymal resection extension, and not nodal dissection.

As for the conclusions, the authors do not explain if limited surgery is recommended for <1 cm solid nodules, and the only suggestion is intraoperative nodal evaluation to prevent loco-regional failure in pure-solid, SUVmax > 2.5 tumours. We think that this considerations are mandatory. First of all, nodal involvement could probably be excluded only in selected pure-ground-glass opacity (GGO) [2], therefore, we always perform and suggest nodal sampling in every other type of neoplastic pulmonary nodule. Secondly, if nodal involvement is suspected, oncological radicality is not guaranteed by limited parenchymal resection because of incomplete intraparenchymal lymphatic pathway resection [3].

We conclude that limited surgery should be considered as a second choice when lobar resection is not feasible, and nodal sampling should be performed in every patient affected by non-small-cell lung cancer.

REFERENCE


regarding the appropriate operative strategies for sub-centimetre lung cancers are warranted.

Finally, we hope that our study will pave the way for a more refined treatment strategy in dealing with sub-centimetre lung cancer.

REFERENCES


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