

Letters to the Editor

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Synchronous bilateral typical carcinoid of the lung

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We read with interest the paper of Beshay and colleagues [1]. It is an interesting report about an unusual presentation of synchronous bilateral typical carcinoid (TC) of the lung, treated with resection.

The authors report that the patient was referred with diagnosis of bilateral lung metastases of unknown origin. Past history was unremarkable for surgical procedures and smoking history. Presumably (although not stated by the authors), a preoperative cytological diagnosis with fine needle aspiration biopsy (FNAB) would have resulted inconclusive because of the small size of the lesions.

We have two questions and one suggestion for the authors.

(1) The authors performed a wedge resection for the biopsy of the right nodule, followed few days later, by a redo-thoracotomy with a right upper lobectomy and systemic lymphadenectomy. The approach looks rather unusual since it exposes the patient to two surgical procedures. A biopsy of the node with intraoperative frozen section would have been more appropriate in the present case, followed by a major resection and lymphadenectomy in case of primary tumour. Indeed, in our experience, a frozen section of solitary pulmonary nodule correctly diagnoses a primary tumour even in case of neuroendocrine origin and in this case, lobectomy can be performed during the same surgical procedure. In case of neuroendocrine tumours, frozen section cannot differentiate between typical and atypical carcinoids although this does not change the surgical technique.

We completely agree with the authors' surgical approach: lobectomy and systemic lymphadenectomy is the treatment of choice for TC. Non-anatomical resections expose to high risk of recurrences [2], and must be reserved

only to patients with poor respiratory function and/or severe comorbidities.

(2) Why did not the authors perform a preoperative positron emission tomography (PET) scan? A pulmonary lesion 1.0 cm in size can be detected with this technique [3]. Report describing PET positivity also in neuroendocrine tumours has been recently published in literature [4].

(3) Follow-up in TC is mandatory. Although these tumours have a favourable long-term survival, local relapses and distant metastases are also described. In our experience, we have observed bone, brain and thyroid metastases from radically resected pT1/2N0 bronchial TC years after the intervention. We suggest that the authors should use ¹¹¹In-DTPA-Pentetreotide scintigraphy (Octreoscan), chromogranin A and neuron specific enolase (NSE) serum level dosage in combination with traditional radiological imaging techniques, for a correct follow-up. We found Octreoscan highly effective in early detection of local recurrences or distant metastases in neuroendocrine tumours of the lung, sometimes before the appearance of symptoms [5]. Further, high chromogranin A and NSE serum levels should be used as early markers of possible relapses.

Finally, they are to be congratulated for this very interesting report and for their correct surgical management of the bilateral synchronous neuroendocrine tumour of the lung.

References

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