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References

PNEUMONECTOMY AFTER INDUCTION RADIOCHEMOTHERAPY: IS IT TIME FOR A META-ANALYSIS?
To the Editor:
The discussion regarding the safety and feasibility of pneumonectomy for non–small cell lung cancer after induction chemoradiotherapy (IT) is a long-standing, widely debated issue, in particular, in the past 2 decades.
We read with great interest the review from Krasna, in which pneumonectomy after IT is finally judged as a risky procedure (especially if right-sided) that, until further validation (via prospectively gathered data), should be “used with caution in experienced centers.”
We wish to express our viewpoint and ask the authors about their opinion on the basis of our own long-term experience with IT, our recently reported results on pneumonectomy after IT, and in the light of other recently published authoritative reports. In particular, we have evaluated the outcome-related data of 85 (49 after IT) consecutive standard pneumonectomies in a 14-year period. Operative mortality and morbidity do not seem to be directly associated with IT; besides, among the clinical, surgical, and pathologic features, the right-sided pneumonectomy showed a worse long-term survival in the overall population regardless of the prior application of IT. Substantially, the same old questions still stay unanswered: Is pneumonectomy a feasible and safe procedure after IT? Are there criteria to stratify the correlated risk after IT-pneumonectomy? Do long-term oncologic results justify this treatment?
On top of this, it is impossible not to consider that a complete resection (thus including the pneumonectomy option) must be attempted if a radical chance of cure is sought and the conditions for resectability are met or re-met after IT.
Still, the indication for pneumonectomy after IT is not yet strictly evidence-based, and a prospective approach is difficult to imagine given the substantial impossibility to design a trial with a proper control group: radical resection in NSCLC, in fact, has no ethical comparator alternative. As well, when the concept of “experienced center” is analyzed, the criteria to define it are in doubt? If present, are these criteria validated? What is the referral benchmark of this validation: survival or mortality/morbidity? What is the correct (ethical) approach to the information given to the patient when a pneumonectomy is offered after an IT?
In our opinion, in reality, the “experienced centers” are those in which the