

References

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Reply to the Editor:

We thank Drs Khandani and Detterbeck for their insightful comments on our article. Its main conclusion was that standard uptake values (SUVs) obtained from positron emission tomographic (PET) imaging were not useful for staging lung cancers smaller than 2 cm. We note that there was no disagreement with that conclusion, but rather the suggestion that visual inspection by experienced readers is now the accepted standard. A listing of some of the technical reasons why SUVs can be misleading is then given.

We agree that several recent articles have suggested that an expert reading may be equivalent to or better than a single cutoff for SUV. However, this is by no means a generally accepted standard. In fact, clinicians overwhelmingly continue to use the maximum SUV for differentiating benign from malignant lesions. This clinical practice is influenced by early PET reports,¹ in which a remarkably high accuracy of SUV was reported for differentiating benign from malignant nodules.

The problems outlined by Drs Khandani and Detterbeck regarding the limitations of the maximum SUV also affect the capability of experienced clinicians in making evaluations. Ultimately, anything that limits the ability to make quantitative assessments will also affect semiquantitative or nonquantitative assessments as well. The latest efforts in PET imaging include adding some form of gating to improve quantitative assessments, and likely there will

again be discussion of whether this will become the new accepted standard. For now, the maximum SUV continues to be reported and to guide clinical practice. We look forward to improvements in PET technology and remain hopeful that the utility of PET for small lesions will improve; however, there are some fundamental limitations that we believe will continue to be problematic in the foreseeable future.

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Pulmonary lobectomy for cancer in patients with chronic obstructive pulmonary disease

To the Editor:

We have read with interest the report from Baldi and colleagues¹ reporting their experience with pulmonary lobectomy for lung cancer in patients with chronic obstructive pulmonary disease (COPD).¹ On the basis of their retrospective evaluation of 137 patients, they concluded that patients with mild-to-severe COPD could have a better late preservation of pulmonary function after lobectomy than healthy patients. As discussed in a very precise way by the authors, this fact is related to a general improvement of the airway caliber and elastic recoil that could be, in its turn, related to relief of hyperinflation, chest wall mechanics, or both, even if in the nonemphysematous lung. In addition, resection of dead space could have its role.

We would like to briefly comment on these figures, trying to relate them to the possible role a pulmonary rehabilitation (PR) program might have in this kind of surgical population, and kindly ask for the authors to disclose their point of view according to their experience.

Today there is body of evidence regarding the efficacy of PR in the comprehensive management of patients with respiratory

disease, and PR programs are practiced worldwide.² Positive results in terms of improvement in dyspnea, exercise capacity, and quality of life are recognized in chronic obstructive and nonobstructive pulmonary disease, including COPD, cystic fibrosis, and restrictive thoracic disease.^{3,4}

Our group has a timely established interest in the issue of PR applied to patients who have undergone (or are candidates for) resection for lung cancer, and we have reported evidence that patients who underwent PR after pulmonary resection demonstrated a better improvement than those who, at discharge from the surgical unit, did not attend any postoperative rehabilitation protocol. In fact, we have reported that an early postoperative rehabilitative intervention prevents deterioration and speeds up recovery of function, with direct effects on ventilatory, gas exchange, and hemodynamic parameters (work of breathing, lung compliance, alveolar-arterial difference, maximum oxygen consumption, arterial oxygen tension, heart rate, arterial lactate concentration, cardiac index, and pulmonary artery pressure) and little or no significant effect on static and dynamic lung volumes, according to previously outlined experiences.⁵ Further analysis (data submitted for publication) of our experience supports this evidence. Because it appears that only patients with mild-to-severe COPD obtain an improvement in terms of lung volumes (related to the preoperative COPD index also)¹ from the removal of lung parenchyma associated with resection for cancer, we would like the authors to comment on the fact that a postoperative rehabilitation program adopted in these patients could improve ventilatory, hemodynamic, and gas exchange parameters concurring to a better clinical outcome and quality of life status.

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