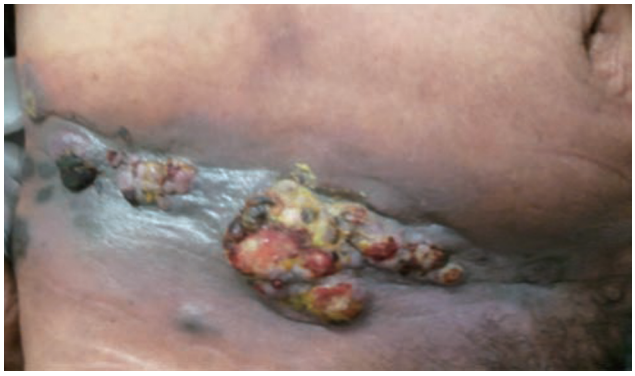

FIGURE 1. Multiple skin lesions occurring on right lower quadrant of the abdomen. Some tumors have undergone self-destruction and fusion.

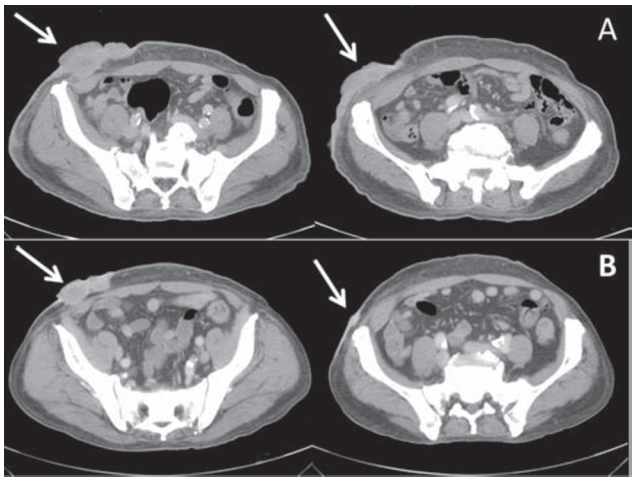

FIGURE 2. *A,* Abdominal CT showing multiple skin lesions in the right lower quadrant of the abdomen and tumor infiltration to subcutaneous tissue. *B,* CT after six cycles of gemcitabine, revealing significant reductions to tumors. CT, computed tomography.

gemcitabine monotherapy as a promising therapeutic option for patients with unresectable epithelioid angiosarcoma.

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Low-Dose Computed Tomography
Could It be Applied for Secondary Prevention in Patients Undergoing Resection for Lung Cancer?

To the Editor:

In the January issue of *Journal of Thoracic Oncology*, Field et al.[1] reemphasize the recently published results of the National Lung Screening Trial (NLST) regarding the role of low-dose spiral computed tomography (CT) as a screening modality in heavy smokers. The Strategic CT Screening Advisory Committee is currently engaging professional societies to focus on delivering clear guidelines and recommendations in this regard. Notably, NLST showed that primary prevention with low-dose CT in heavy smokers led to 20% fewer deaths from non–small-cell lung cancer (NSCLC) when compared with screening via old-fashioned chest radiographs.[2] There is no doubt that recent technical developments have revolutionized CT capabilities and, as a result, its clinical applications. However, cost-effectiveness of this screening modality and the amount of overdiagnosis in the NLST remains to be clarified before recommending it for general practice.[1,2] Confounding comorbidities and practical hurdles may further reduce this screening's efficacy, as 89% of smokers will never develop lung cancer.

Conversely, it is known that 20% of completely resected Stage I NSCLC patients do develop recurrent lung cancer, most commonly to the thorax and usually within the first years postoperatively.[3] The recurrence rate more than doubles for the

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operated tumor, node, metastasis Stage II NSCLC patients. Therefore, an effective secondary prevention is imperative in these patients to ensure the best outcomes.

Notwithstanding, it has been shown that lung cancer patients often receive a higher dose of radiation with conventional-dose CT than that considered safe, which could increase significantly their already increased lifetime cancer risk.[4] As a result, strategies are stringently needed to decrease radiation doses during the postoperative follow-up in these patients, the majority of whom will never relapse. Given the results of NLST, it seems that utility of low-dose CT should also be tested in these patients who have completed curative treatment, but who remain at increased risk for recurrent disease. Further studies of the underlying economic, psychosocial, and physical barriers of low-dose CT in this population are probably warranted.

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Induction Chemotherapy Inevitably Leads to Inferior Outcome in Combined Modality Treatment for Unresectable Stage III Non-small Cell Lung Cancer

To the Editor:

We read with interest the recent retrospective report of Chen et al.[1] on the deleterious effects of delayed initiation of radiotherapy (RT) after induction chemotherapy (CHT) in stage III non-small cell lung cancer (NSCLC) due to tumor regrowth occurring within a few weeks. They have concluded that RT treatment planning should begin as soon as possible after the administration of induction CHT to maximize its benefits and provided a volumetric analysis of tumors to support their conclusion of accelerated repopulation as the mechanism for regrowth during delays. Their results in fact reconfirm the study of El-Sharouni et al.[2] which compared computed tomography (CT) scans-based assessment of tumor changes before and after induction CHT, with an emphasis on the time interval from the last induction CHT cycle to the timing of the RT treatment planning CT scan. They showed that during the waiting period (for the planning CT scan and start of RT), a total of 41% of all tumors became incurable. Bozcuk et al.[3] recently looked at the benefits of induction CHT before RT in NSCLC using a meta-analytical approach with meta-regression analysis. Using 13 completed randomized clinical trials involving a total of 2776 patients, they found that the time to RT initiation was inversely associated with the benefit from induction CHT at 2 ($p = 0.050$) and 3 years ($p = 0.093$).

As noted by the authors, a range of prospective randomized clinical trials followed by recent meta-analyses[4] have confirmed that in unresectable stage III NSCLC patients meeting the selection criteria for such trials, the standard of care is concurrent RT-CHT, with CHT initiated on day 1 of RT, as compared with sequential CHT followed by RT. Furthermore, the recently published randomized trial (CALGB 39801)[5] of concurrent RT-CHT with or without the addition of induction CHT showed that the experimental arm generated excess toxicity and provided no survival benefit over concurrent RT-CHT alone.[5] With this evidence in mind, the present report by Chen et al. fails to adequately justify their conclusion about future clinical research in this setting without clear upfront patient and/or tumor selection criteria which may prompt an indication for the use of induction CHT. In addition, they identify "logistical/scheduling constraints in 14 of 21 cases" which are otherwise not characterized as the basis for delays in RT initiation after induction. This suggests a number of variables in their study population which would not conventionally make these patients trial eligible. Without better characterization of their population, it then becomes difficult to understand why one should optimize what is already an inferior (i.e., induction CHT) approach to managing stage III NSCLC but not further optimize the better (RT-CHT) approach associated with the optimal survival.

We share the authors' goals in providing the best care possible for patients confronting locally advanced lung cancer and agree that optimizing the delivery of RT is a priority. The old notion of "doing something while the patient waits for the radiotherapy planning scan" is clearly not tenable. A more detailed analysis of the clinical circumstances in the present series would have further served to justify that proposition.

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