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Restaging patients with N2 (stage IIIa) non–small cell lung cancer after neoadjuvant chemoradiotherapy: A closer look at redo mediastinoscopy

To the Editor:

On the basis of the data obtained by the analysis of 93 locally advanced cases of non–small cell lung cancer clinically restaged after induction therapy, Cerfolio and coworkers1 conclude that when repeat positron emission tomography (PET)/computed tomography (CT) is adopted either in the staging or restaging process, the percentage decrease in maximum standardized uptake value (maxSUV) of the primary tumor and involved lymph nodes is predictive of pathology, but pathologic assessment is still required because persistently high maxSUV “does not equate to residual cancer.” We commend the authors for their valuable study. Along the line of discussion, Cerfolio and coworkers state that “repeat mediastinoscopy often is inaccurate and potentially dangerous, especially after chest irradiation” and that endoscopic ultrasonography–guided fine-needle aspiration (EUS-FNA) biopsy, despite being more precise and accurate, is “available only in few centers.” We would like to amicably address the authors on this point on the basis of our own personal experience and confidence with redo mediastinoscopy. Pathologic reassessment of the mediastinum is strongly advisable in the setting of induction therapy for locally advanced non–small cell lung cancer because persistent N2 disease heralds a poor prognosis.

Shortly after the introduction of mediastinoscopy, redo procedures were considered to be technically impossible be-
The very interesting data coming from the EUS-FNA series pave the way for a constructive discussion. An alternative strategy to avoid redo mediastinoscopy consists of initial proof of mediastinal node involvement by means of EUS-FNA, followed by induction chemotherapy and, afterward, mediastinoscopy to evaluate mediastinal response. In this way a technically more demanding redo mediastinoscopy can be avoided by thoracic surgeons having no experience with this technique. We would appreciate the authors’ comments on these remarks.

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References

Reply to the Editor:
Dr Cesario and colleagues have posed some important and interesting questions concerning the role of repeat mediastinoscopy after induction radiotherapy. We need to limit our comments to patients who have had radiotherapy because that is the real issue and not those who had chemotherapy alone. The authors state that “pathologic reassessment of the mediastinum is strongly advisable,” and we, as our article clearly outlines, agree. The table the authors show compares a clinical staging modality, positron emission tomography (PET)/computed tomography with a pathologic staging procedure (repeat mediastinoscopy). As we have preached and written, pathologic staging always trumps clinical staging, and thus this comparison is unjustified. Repeat PET/computed tomography directs biopsies by providing targets for biopsy, as we clearly state. The question is as follows: What is the safest and most accurate way to achieve rebiopsy of previously cancerous N2 mediastinal lymph nodes after induction chemoradiotherapy? Although there is little doubt that repeat mediastinoscopy can be performed safely (as we have done several times ourselves), we do not recommend it on a national basis nor do we believe it is accurate in most surgeons’ hands. The authors are biased by their own skill and might not realize that the vast majority of these patients are not seen by surgeons who have their type of expertise. If we send out the message that repeat mediastinoscopy after radiotherapy is safe and accurate or is “the standard of care,” I fear the subsequent morbidity and even mortality that might ensue. A large number of patients in the United States with lung cancer receive their surgical care from less-experienced hands than those of Drs Granone, Schil, and Cesario. The message from our literature must take this fact into account. I do not believe that repeat mediastinoscopy after chest irradiation is safe or accurate in the typical center. In fact, although it might be safe in select hands, the accuracy is still in doubt. Careful analysis of the articles referenced by the authors’ letter shows the relatively high morbidity for mediastinoscopy for those who had radiotherapy (not chemotherapy alone). Thus