

Reply

Reply to the letter to the editor "Comment on 'Pre- and intra-operative mediastinal staging in non-small-cell lung cancer'"

Didier Lardinois

Universitätsspital Basel, Klinik für Thoraxchirurgie, Basel, Switzerland

Letter to the Editor:

<http://www.smw.ch/content/smw-2011-13289/>

In response to the comments by von Garnier, I would like to give some precise comments and point out some aspects in the interpretation of the study by Annema et al.

1. The study shows that endoscopic mediastinal staging followed by surgical staging (mediastinoscopy) has a better accuracy than mediastinoscopy alone and than endoscopic staging alone. There was no significant statistical difference between surgical staging alone and endoscopic staging alone. In the combination of both staging procedures, an increase of staging accuracy was a result of surgical staging following endoscopic staging, since mediastinoscopy revealed a false negative value of 9.2% after endoscopic techniques. This underlines the important role of surgical staging.
2. As mentioned in the paper, a large amount of experience with endoscopic techniques is only available in a few centres. In this respect, the combination of these techniques with surgical staging procedure cannot be recommended as a routine standardised staging strategy.
3. In the arm of surgical staging alone, false negative results were found in 16/65 (24.6%) patients who underwent thoracotomy at final histological findings. From these 16 patients, unforeseen lymph node metastases were found in 10 patients. It would have been interesting to know if these lymph nodes were PET-positive or not. Indeed, it has been shown that patients with clinical lymph node metastases in the lower mediastinum also have, in most of the cases,

metastases in lymph node stations located in the superior mediastinum (reachable by mediastinoscopy). Moreover, in patients with PET-negative superior mediastinum, the probability to find node metastases in other stations is lower than 10% [1]. In most of these cases, such metastases are PET-negative and defined as micrometastases (minimal N2) on definitive histological findings. This point is very important since it strongly highlights the significance of "unnecessary thoracotomies" as mentioned in the paper. Indeed, such patients can be adequately oncologically treated by radical surgical resection and adjuvante chemotherapy instead of by induction treatment followed by surgery. A reasonable prognosis can be expected after primary surgical resection.

In conclusion, recent papers indicate that the combination of several techniques for mediastinal staging in patients with NSCLC increases staging accuracy. Surgical staging is more invasive but remains an important tool, since it increases staging accuracy of endoscopic techniques alone when performed after these techniques. Again surgical and endoscopic techniques should be considered as complementary and not as competitive techniques.

Correspondence: Professor Didier Lardinois, Universitätsspital Basel, Klinik für Thoraxchirurgie, Departement Chirurgie, Spitalstrasse 21, CH-4031 Basel. dlardinois@uhbs.ch

1 Verhagen AT, Bootsma GP, Tjan-Heijnen VCG, van der Wilt GJ, Cox AL, Brouwer MHJ, et al. FDG-PET in staging lung cancer. How does it change the algorithm? *Lung cancer*. 2004;44:175–81.