Author's Reply

To the editor: First of all we would like to thank Dr Muñoz and colleagues for their letter, as it helps to keep the debate about lung cancer treatment alive. Obviously in our editorial we expressed a personal opinion, in the knowledge that there may be other specialists that do not agree with this analysis of the situation. It is also our personal opinion that asthma, tuberculosis, and sleep disorders, among other entities, are respiratory illnesses that should be treated by pulmonologists.

No one questions the need to create multidisciplinary teams that include oncologists for lung cancer treatment. However, as we stated in our editorial, given that lung cancer is a disease of the respiratory system that is usually diagnosed by pulmonologists, we believe that pulmonologists should be directly responsible for the clinical treatment of lung cancer patients and that clinical treatment definitely includes the administration of chemotherapy. Unfortunately, and contrary to the assertion made by Dr. Muñoz and colleagues, the range of treatments available for bronchogenic carcinomas has not greatly increased over the last few years. In phase III randomized trials of cytotoxic chemotherapy plus new substances, such as tyrosine kinase inhibitors and matrix metalloproteinase inhibitors of the epidermal growth factor receptor, no improvement in survival has been observed.[1,2] The truth is that available treatments have recently become simplified by the introduction of oral preparations that make administration less complicated in specialized day hospital units. There is no comparison between chemotherapy and the complexity of thoracic surgery or radiation oncology. In fact, in other European countries, as we also mentioned in our editorial, the training needed to deal with lung cancer chemotherapy is included in the curriculum for the specialty of pulmonology.[3,4] For this reason lung cancer chemotherapy is within the competence of pulmonologists in most of Europe—which is the sociopolitical context we now belong to and will continue to form a part of.

Muñoz and colleagues claim exclusive rights to the treatment of bronchogenic carcinomas and even use the term "encroachment" to describe our simple difference of opinion. We feel obliged to remind them that our degree in medicine allows us to treat patients and that in the European context of which we are now a part, the term "encroachment" cannot be applied to pulmonologists who are treating a pulmonary disease. Nevertheless it seems to make more sense to Muñoz and colleagues for the treatment of patients with pulmonary disease to be the responsibility of specialists who only dedicate a small part of their professional activity to the lung, even though most of the complications of this disease are also of a pulmonary nature.[5]

Lastly we insist that the health care of many European countries, where it is normal practice for pulmonologists to take charge of lung cancer treatment, has nothing in common with the witchcraft that Muñoz and colleagues so surprisingly refer to. On the contrary the patients of these countries benefit from treatment for respiratory problems directed by a specialist in lung disease.

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