

LETTERS TO THE EDITOR

Identifying cyN0 Bronchogenic Carcinoma

To the Editor: The letter by López-Encuentra et al¹ on the multimodal treatment of clinical non-small cell N2 bronchogenic carcinoma confirmed by cytology and histology ends with a question that deserves our full consideration: How do we identify patients whose tumors have shrunk from cN2 (C3) to cyN0 (C3) following induction? Selecting these patients is relevant because they are the only ones who benefit from surgical resection once induction has been completed.^{2,3}

Although there are several ways of reexamining the affected lymph nodes after induction (transbronchial and transesophageal puncture, transparietal puncture, mediastinoscopy, thoracoscopy, and repeat mediastinoscopy), mediastinoscopy is the technique most often used for clinical classification of lymph nodes, and repeat mediastinoscopy following induction is the technique that has been used most systematically—though in few hospitals—to evaluate tumor response. When performed systematically, repeat mediastinoscopy attains levels of sensitivity and precision and a negative predictive value very close to those of staging mediastinoscopy. However, it is not possible to predict in the short term how widespread its use will become as it is difficult to perform due to peritracheal adhesions. It will thus be of the greatest clinical necessity to integrate endoscopic examinations and puncture procedures to avoid staging mediastinoscopy. A positive puncture result, in the right clinical context and complemented with images, gives sufficient information for initiating induction therapy. Once induction therapy has finished, the same endoscopy technique could be used to evaluate tumor response: if the new puncture were positive, the patient would be excluded from surgical treatment. However, surgical examination techniques (mediastinoscopy, mediastinotomy, or thoracoscopy) would tend to be used in cases where punctures were negative because the negative predictive value of punctures is currently low. Integrating punctures into the diagnosis and classification process would avoid the need, in many cases, for staging mediastinoscopy and, as a result, repeat mediastinoscopy.

The problems do not end here. In light of the results of the 2 clinical trials^{2,3} mentioned by López-Encuentra et al,¹ we should ask a further question: Is lung resection really necessary in patients whose tumors have shrunk from cN2 (C3) to cyN0 (C3) as a result of induction therapy? We know that these patients live longer than those with persistent lymph-node involvement but we do not know with the kind of certainty that today's clinical practice requires whether they would live longer with no further therapy or with further nonsurgical therapy. Only a new clinical trial that randomly assigns surgical and nonsurgical therapy to patients with cyN0 (C3) tumors can answer this question.

To finish, what do we do when all mediastinal lymph nodes are resected using emerging surgical staging techniques and, where indicated, induction therapy has begun? Both video-assisted

mediastinal lymphadenectomy^{4,5} and extended transcervical mediastinal lymphadenectomy⁶ involve the resection of almost all the mediastinal lymph nodes. While they perform staging, they eliminate the substrate that should be reevaluated following induction. It can be said that, as well as staging, these techniques form part of the induction therapy as they reduce, by surgical methods, the anatomical extent of the tumor before final therapy. As the most indicative parameter in terms of prognosis is the node stage following induction, the absence of lymph nodes to reevaluate in these cases means that we must find other parameters that indicate whether resection is advisable. This is a new clinical situation that may occur if the practice of these cervical lymphadenectomy techniques becomes widespread. Regardless of the therapeutic value of these techniques (which has yet to be shown), the immediate advantage is the increased sensitivity, precision, and negative predictive value in relation to mediastinoscopy.

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