New Endoscopic Ultrasound (EUS) Applications in Lung Cancer: Evaluation of Patients With Negative Mediastinal CT and Re-Staging After Neoadjuvant Treatment

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Abstract

The main purpose of staging in non-small cell lung cancer (NSCLC) is to assess mediastinal lymph node involvement, with thoracic CT being the main non-invasive test for this. However, given that up to 15% of patients who show no mediastinal lymph node involvement in the CT has lymph node metastasis during surgery, other examinations are required. Endoscopic ultrasonography guided fine-needle aspiration (EUS-FNA) was shown to be able to detect advanced disease (metastatic mediastinal lymph nodes, adrenal metastasis, mediastinal invasion by the tumor) in approximately 25% of patients with a CT that suggested a non-advanced disease.

Another situation in which CT has a very limited value is in the evaluation of the response to induction therapy, with its most limiting factor being its intrinsic inability to distinguish between a tumor and necrosis. In this context, EUS-FNA was shown to have a good performance, with a sensitivity, negative predictive value and precision of 75%, 67%, and 83%, respectively.

In conclusion, EUS-FNA may be considered a good alternative in the pre-operative staging of patients with NSCLC, with and without diseased mediastinal lymph nodes in CT, and could play an important role in the mediastinal re-staging of these patients by identifying a patient sub-group who might benefit from additional surgical treatment.

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The main objective of staging in non-small-cell lung cancer (NSCLC) is mediastinal evaluation. Precise mediastinal evaluation is fundamental for determining the prognosis and treatment for these patients, as the presence of mediastinal lymph node involvement means stage IIA or IIB disease. This translates into the need for neoadjuvant treatment, which may or may not be followed by surgery. Given that 30%-40% of patients with newly diagnosed NSCLC have mediastinal involvement, complementary tests are necessary to evaluate the mediastinum.

There are many options for staging the mediastinum. Thoracic CT is the main diagnostic test for the mediastinal evaluation of bronchogenic carcinomas. The diagnostic criteria for malignancy are the presence of lymphadenopathies whose smallest diameter is larger than 1 mm. According to different studies in the literature, the precision of CT for identifying pathologic mediastinal lymphadenopathies is variable (57%-95%). This precision varies according to the lymph node stations, the highest being for the right paratracheal region and the lowest for the subcarinal region. Up to 15% of patients who do not have lymphadenopathies greater than 1 cm on CT present mediastinal metastasis in surgery.

Given that the presence or absence of metastatic mediastinal lymphadenopathies influences decision-making regarding tumor resectability, CT cannot be used alone for mediastinal staging and histologic confirmation of the lymphadenopathies is imperative. Endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) biopsy has been demonstrated to be highly precise for the evaluation of the lymph node stations located in the mid and posterior mediastinum (regions 4L, 5, 7, 8, and 9, and occasionally 2 and 4R), as well as in the left suprarenal gland, while the peribronchial and hilar regions and the anterior mediastinum are not accessible by EUS-FNA, but are instead accessible by needle aspiration (NA) guided by endobronchial ultrasound (EBUS).

In a systematic review and a meta-analysis of 18 studies that included 1201 patients published by Micames et al., EUS-FNA reached a sensitivity of 83% and a specificity of 97% for mediastinal staging (N2/N3) in patients with lung cancer. The main advantage of EUS-FNA over other non-invasive methods is its capacity to obtain histologic confirmation of the presence of disease. Compared with minimally invasive surgical techniques like mediastinoscopy, EUS-FNA (like NA guided by EBUS) only requires conscious sedation, can be done routinely in an outpatient setting and has been demonstrated to be more cost-efficient. The effectiveness of the different techniques used for staging NSCLC is detailed in Table 1.

There are two clinical situations in patients with NSCLC that pose a special diagnostic problem in which EUS-FNA is a good alternative and offers a new perspective: the evaluation of patients with negative mediastinum on CT, and re-staging after neoadjuvant treatment.

EUS-FNA in Lung Cancer in Patients With Normal Mediastinum on CT

The management of patients with NSCLC without signs of mediastinal affection on CT is still open for discussion. EUS can detect mediastinal nodules of up to 2-3 mm. Therefore, EUS is able to detect adenopathies smaller than 1 cm considered irrelevant by CT and even obtain a sample from them to either confirm or rule out the affection of the lymph nodes. Four prospective studies have evaluated EUS-FNA in patients with NSCLC without pathologic lymph nodes on CT, showing that EUS-FNA is able to detect advanced disease (mediastinal metastasis, suprarenal metastasis, tumor invasion of the mediastinum) in approximately 25% of the patients whose CT showed only non-advanced disease (Table 2). Wallace et al. published a study in which EUS-FNA identified N2–N3 lymph node metastasis in 14 out of 67 patients (21%). There were also 9 false negatives due to either a sampling error (n=5) or to the presence of metastasis in pre- and paratracheal lymph nodes that were not visualized by EUS (n=4). In another study, LeBlanc et al. identified N3 metastasis in 5 out of 67 patients (7%) by means of EUS-FNA. EUS avoided surgery in 9 patients (13%), not only due to the N3 affection (n=5) but also by detecting celiac metastatic lymphadenopathies (n=2), tumor invasion (n=1) and synchronous esophageal cancer (n=1). In another 9 patients, EUS had an impact in management by detecting suprarenal benign lesions (n=8) and a hepatic lesion (n=1). In total, the findings of EUS changed the patient management in 25% of cases. In the surgical staging of the remaining 62 patients in whom mediastinal disease was not diagnosed, lymph node metastasis was found in 17 more patients.

The prevalence of mediastinal metastasis in these two studies (35% and 36%, respectively) is higher than that of other surgical series, which suggests a bias in favor of the EUS either due to the inclusion of patients with lymphadenopathies that are “borderline” in size or because more samples were taken than normal (normally 4 or 5 aspirations per lesion in the study by Wallace et al.). In the study by Fernández-Esparrach et al., EUS-FNA demonstrated metastasis in N2–3 lymphadenopathies in 5 out of 47 patients (11%). There were 5 false negatives that were due to micrometastasis (n=1), the lack of need to perform FNA due to benign morphological appearance (n=3) or to the presence of metastasis in a lymphadenopathy that was not visible by EUS (n=1). In this study, the EUS-FNA was done when one or more of the classic ultrasound criteria of malignancy by EUS were present (hypoechogenicity, round shape, well-defined edges, size>5 mm). Consequently, three metastatic lymphadenopathies (in two patients) visualized by EUS were not considered tributaries of EUS-FNA.

Therefore, in the mediastinal staging of NSCLC, the use of classic criteria for malignancy should be reconsidered. The reasons for the low sensitivity of these criteria have not been researched specifically. However, given that it is common to find inflammatory mediastinal lymphadenopathies in healthy patients, one might think that the infiltration of the lymphadenopathies by metastatic cells would not necessarily change the morphologic characteristics of the preexisting lymphadenopathies. In this way, any mediastinal lymphadenopathy would be a candidate for being aspirated in patients with NSCLC. Finally, it is well known that mediastinal lymphadenopathies can contain foci of micrometastasis in patients with NSCLC. Therefore, a more exhaustive analysis of all the visible mediastinal lymph nodes and the addition of NA guided by EBUS for exploring the regions that are not accessible by EUS would improve the diagnostic performance of EUS-FNA in these patients.

Mediastinal Re-Staging After Neoadjuvant Therapy

Mediastinal re-staging in patients with NSCLC after induction of chemotherapy is a controversial point. CT and MRI have limited
value due to the intrinsic inability of these techniques to differentiate between tumors and necrosis, and therefore their precision is low. On the other hand, PET is not a good predictor for the response to chemotherapy, either by the primary tumor or by the lymphadenopathies. Recent studies have demonstrated that NSCLC patients with metastases in ipsilateral lymphadenopathies that were understaged with induction of chemotherapy had significantly higher survivals after surgical resection compared with those patients with persistent N2 disease. The results of a recent systematic review advise against the use of PET for mediastinal lymph node re-staging as its effectiveness is not very good (sensitivity 63.8% [95% CI: 53.3%–73.7%] and specificity 85.3% [95% CI: 80.4%–89.4%]).

Recent studies have demonstrated that NSCLC patients who have not been treated with chemotherapy, but are very similar to those published by other authors, have a paraesophageal tumor not detected by EUS in one case. These findings should be confirmed by means of surgical staging prior to thoracotomy. However, and due to the fact that the histologic confirmation is necessary, EUS-FNA is the first-choice procedure for mediastinal re-staging.

Table 3

<table>
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<th>No.</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>Dx Precision</th>
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Some of the reasons of this low NPV of NA guided by EBUS are the following:

1. After chemotherapy, the lymphadenopathies that initially contain tumors present necrosis and fibrosis and are more difficult to biopsy, while the quantity of cell material for analysis is less.
2. The malignant cells can be found focally inside the lymphadenopathy in the interior of dense areas of extracellular matrix.
3. The presence of necrosis within the aspirated sample often makes the pathological evaluation more difficult.
4. There was no in situ evaluation by the cytologist, which possibly would have been able to increase the sensitivity for the detection of malignancy.
It is important to remember the different territories that are usually accessible by EUS and EBUS. EBUS enables access to the paratracheal (stations 2, 3p, and 4), subcarinal (station 7), hilar (station 10) and interlobar (station 11) regions. By means of EUS, we can visualize the regions of the posterior–inferior mediastinum (stations 4L, 5, 7, 8, 9, and occasionally 2 and 4B). Given that these techniques are complementary, the combination of both could improve their precision. Furthermore, it has been demonstrated that the sequential performance of EUS and EBUS is well tolerated by the patients when done under conscious sedation.

In conclusion, EUS-FNA should be considered in the mediastinal staging of patients with NSCLC with and without pathologic adenopathies by CT and in the mediastinal re-staging after neoadjuvant treatment.

Conflict of Interests

The authors declare having no conflict of interests.

References


