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Letters to the Editor

Incisional Metastasis From Lung Cancer After Transcervical Extended Mediastinal Lymphadenectomy☆

Metástasis incisional de carcinoma broncogénico tras linfadenectomía mediastínica transcervical extendida

To the Editor:

New lung cancer staging techniques, such as transcervical extended mediastinal lymphadenectomy (TEMLA) and video-assisted mediastinal lymphadenectomy (VAMLA), provide sensitivity and specificity figures of close to 100%, thanks to the extensive nature of the procedure and the large amounts of lymph node collected. On the other hand, these techniques are highly invasive and their benefits have been questioned.[1] Our surgical team only performs TEMLA in 2 types of patients: operable patients with N0-1 lymph node staging and a high prevalence of N2 disease, to avoid false negatives on mediastinoscopy; or in patients with a high comorbidity burden, to avoid high-risk thoracotomy in patients for whom this intervention would not benefit survival if they turn out to have N2 disease. We report the case of a patient subjected to TEMLA staging who developed incisional metastasis. This is the first report of this kind in the medical literature.

A 72-year-old man presented with multiple comorbidities, including left hilar lung cancer, 55 mm×56 mm with undetermined station 4R and 6 lymph nodes. TEMLA was used to obtain 28 nodes from stations 1+3, 2R/L, 4R/L 5, 6, 7 and 10R/L (Mountain–Dresler classification). Disease was confirmed in multiple stations, with malignancy in stations 10L, 5 and 6. Rescue surgery was indicated after induction chemotherapy, but the patient was finally deemed inoperable due to intrapericardial arterial infiltration. Three months later, he developed a tumor in the site of the TEMLA scar, which was resected with local anesthesia (Fig. 1). Histological examination confirmed metastasis of the primary tumor. The patient died due to progressive disease 23 months later.

Recurrence of lung cancer in surgical wounds is very rare, although reports have been published of implants in surgical wounds following open lung resection or thoracoscopy, and in mediastinoscopy incisions. The low prevalence of recurrence makes it difficult to determine if the primary cancer cell type or degree of differentiation is associated with the incidence of this type of relapse.[2] With regard to incisional recurrence in surgical scars after staging, the meta-analysis published by Ashbaugh in 1970 estimated that implants in the mediastinal incision occur in 0.12% of procedures[3]; the incidence of this type of lesion after maximal staging techniques is unknown – indeed, no case has been reported to date. The greater invasiveness (Fig. 1) and volume of lymph node obtained in TEMLA – both factors impacting on the genesis of incisional metastasis – prevent any assumption that the incidence of incisional metastasis is comparable to mediastinoscopy.

The detection of the first case of metastasis in a TEMLA scar sets the rate of incisional metastasis in our patient series at 0.09%.

The etiology and pathogenesis of these lesions are still to be clarified, but related factors include lymph node or hematogenetic

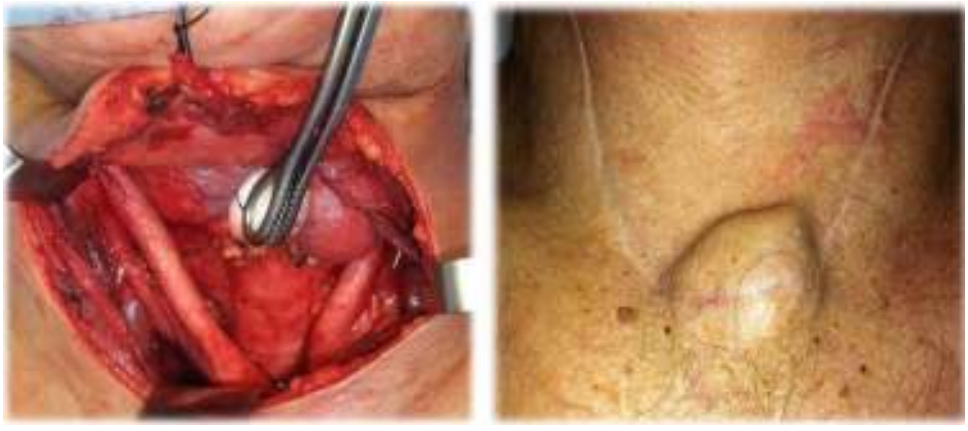

Fig. 1. Surgical field and incisional metastasis 1.8×1.4 cm in the TEMLA scar.

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dissemination to the hypervascularized wound – which would occur in disseminated stage disease – and the local shedding and implantation of malignant cells,[4] in which case the staging defined in the primary staging would not be affected, and long-term survival would remain a possibility.[5] In our specific case, the patient's extended survival supports the second of the above-mentioned etiopathological mechanisms.

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Mixed COPD-asthma Phenotype: ACOS or CAOS? A Reflection on Recent Guidelines and Recommendations☆

¿Fenotipo mixto EPOC-ASMA, ACOS o CAOS? Una reflexión sobre las guías y recomendaciones recientes

To the Editor:

The combination of COPD and asthma in the same patient still raises controversy in international and national guidelines.[1–5] The phenomenon (mixed COPD-asthma phenotype in Spanish)[1] is called asthma-COPD overlap syndrome – ACOS – in English, but the range of diverging definitions (Table 1) suggests that "chaos" might better describe the current situation.

The Spanish COPD Guidelines (GesEPOC)[1] and other similar documents[2,3] recommend evaluating the presence of major and minor criteria, but these do not include clinical symptoms in asthma patients, such as rhinitis, polyposis or wheezing, or seasonal or diurnal variability. Moreover, these guidelines do not address response to corticosteroid treatment, while great importance is given to the bronchodilator test or certain allergic sensitization criteria. The assessment of Th2 inflammation is recommended, but this procedure cannot be performed in routine clinical practice, yet other more accessible variables, such as FeNO or peripheral eosinophilia, are omitted. Moreover, these guidelines, drawn up from the standpoint of COPD, ignore the existence of neutrophilic asthma, a major clinical problem in this setting.

In the GOLD-GINA[4] initiative, ACOS is determined on the basis of a numerical score calculated from clinical, functional and radiological criteria characterizing COPD and asthma. This approach makes greater clinical sense, but it seems to lack specificity, and overlooks essential elements, such as smoking history.

Finally, the Spanish Guideline for the Management of Asthma (GEMA)[5] recommends that a stepwise approach be taken in patients whose clinical course is indicative of overlapping asthma and COPD. These steps include the attempt to treat with oral corticosteroids, a post-bronchodilator test (the benefit of which in COPD is currently under debate), or a methacholine bronchial challenge test (contraindicated in many of these cases).

We should emphasize that the only thing clear about ACOS is that patients with this syndrome benefit significantly from the inclusion of inhaled corticosteroids in their treatment regimens. As things stand, different treatments could be prescribed for the same patient, depending on the recommendations followed. In our opinion, scientific societies and working groups should work together to produce common criteria that will help clinicians to reach the right decisions.

Table 1
Characteristics and Parameters Guiding the Characterization of the Asthma-COPD Overlap Syndrome (COPD-Asthma Mixed Phenotype) According to Different Guidelines and Initiatives.

	GesEPOC	CPPS	FMSD	GOLD/GINA	GEMA
Family history of asthma and/or atopy	No	No	No	Yes	Yes
Personal history of asthma	Yes	Yes	Yes	Yes	Yes
Personal history of atopy	Yes	Yes	Yes	No	No
Marked or seasonal variability of symptoms	No	No	No	Yes	Yes
Rhinitis/sinusitis	No	No	No	No	Yes
Highly positive bronchodilator test (↑ FEV1≥15% and ≥400 ml)	Yes	Yes	Yes	Yes	No
Positive bronchodilator test (↑ FEV1≥12% and ≥200 ml)	Yes	Yes	Yes	Yes	Yes
Significant variability in FEM	No	No	Yes	Yes	No
Positive bronchial challenge	No	Yes	No	No	Yes
Positive oral corticosteroid test	No	No	No	No	Yes
Improvement with inhaled corticosteroids	No	No	No	Yes	No
Raised total IgE	Yes	Yes	Yes	Yes[a]	No
Eosinophilia in sputum	Yes	Yes	Yes	No[a]	Yes
Peripheral eosinophilia	No	No	No	Yes[a]	Yes
Raised FeNO	No	Yes	Yes	Yes[a]	Yes
Positive skin prick tests	No	No	No	Yes[a]	No

CPPS, Czech Pneumological and Phthisiological Society; FMS, Finnish Medical Society Duodecim; GEMA4.0, Spanish Guideline for Asthma Management 4.0; GesEPOC, Spanish COPD Guidelines; GOLD/GINA, Global Initiative for Chronic Obstructive Lung Disease/Global Initiative for Asthma.

[a] Variables which might assist in differentiating between asthma and COPD in the specialist setting, irrespective of their value in the diagnosis of overlap syndrome.

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