Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Bronchoscopy for Bronchogenic Carcinoma

To the Editor:

I would like to address two errors and three areas of controversy in Dr. McCormack's recent editorial (Chest 1983; 83:838). The results of the papers of Popovich et al and by me were incorrectly stated. Popovich et al found that four biopsies of an endobronchial lesion provided the best diagnostic yield, while we found the probability of a positive diagnosis to be .9577 after two biopsies and .9986 after three.

I agree with Dr. McCormack that prompt diagnosis and therapy are important, but I disagree with the implied definition of "prompt," that is, diagnosis and surgical therapy at the same setting. While the capability to obtain a rapid diagnosis by frozen section is convenient, it is not essential. A one- or two-day hiatus while awaiting interpretation of fixed tissue specimens is acceptable and, for many patients, desirable. Many patients wish to use this time to order their affairs prior to surgery or to consider therapeutic options, particularly in cases of stage 3 disease.

I also disagree that the initial diagnostic bronchoscopic examination must be performed by a surgeon. Bronchoscopy should be performed by a competent endoscopist, whether internist or surgeon. In addition to obtaining a diagnosis of the primary lesion, the endoscopist should be able accurately to assess the endobronchial proximal extent of disease for staging. Endoscopic staging is particularly important, since many patients, unfortunately, present with advanced, unresectable disease. The extent of disease can often be determined endoscopically, and such patients need not be seen by the surgeon. In fact, of the 445 patients with stage 3 disease reviewed by Martini et al and cited by Dr. McCormack, 46 percent were considered inoperable at diagnosis because of several factors, including tracheal metastases, malignant pleural effusions, oat cell carcinoma, and medical contraindications to surgery. Thus, a large number of patients will not require surgical resection.

Finally, despite the results of Martini et al., the utility of surgery for stage 3 disease is not clearly established. The 20 percent three-year survival reported in this series reflects the results of surgery (resection and mediastinal node dissection) and postoperative radiation, not the results of surgery alone, as implied by McCormack. In addition, similar results can be found with other treatment modalities. Eagan et al found a 23 percent three-year survival with a combination of radiation and chemotherapy. Aristizabal and Caldwell found a 19 percent three-year survival in limited stage 3 disease with radiation alone in patients with well-differentiated tumors. These results indicate that the best therapeutic approach to stage 3 disease is not clear at this time. While surgery combined with some adjuvant therapy is promising, other forms of therapy may achieve similar results. Current and future studies need to consider a variety of prognostic factors such as patient performance status, tumor type, and degree of tumor differentiation before a clearer picture can emerge.

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REFERENCES

2 Shure D, Astarita RW. Bronchogenic carcinoma presenting as an endobronchial mass. Optimal number of biopsy specimens for diagnosis. Chest 1983; 83:865-67

To the Editor:

I find Dr. McCormack's comments in her editorial very confusing. The question she tries to answer is: which specialist should most appropriately perform the diagnostic test in a given situation, and I assume she is referring to fiberoptic bronchoscopy. Her answer to this question is difficult for me to accept.

The gist of her conclusion seems to be that the thoracic surgeon in the operating room is the specialist who should perform the procedure. Her reasoning is that a biopsy specimen obtained in the operating room can be confirmed within a few minutes. If Dr. McCormack is implying that the patient is anesthetized (and I assume that they are anesthetized since they say they are in the operating room), then is the appropriate treatment (immediate surgery?) undertaken? If so, suppose the diagnosis turns out to be small cell carcinoma. Then I assume no operation is undertaken and the patient has been put through the risk of general anesthesia for nothing. If the patient is in the operating room, but is not anesthetized, is then the bronchoscopic procedure carried out and then if the answer comes back cancer, is the patient then immediately put to sleep and the surgery undertaken at that time?

Also, how does one know that a tumor is endoscopically visible unless one actually performs an endoscopic procedure? Suppose the lesion is not endoscopically visible? One, then, has a patient under general anesthesia, but cannot see a tumor and therefore what does one do at this point? Is transbronchial biopsy then attempted? I know of no thoracic surgeon trained to perform this fluoroscopically guided procedure in the operating room. Or is the patient then

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