based on their comparable survival rates (as of the late 1990s). In fact, many such subsets have little in common except their dismal prognoses.

My point is that yet another revision in the staging system will undoubtedly be necessary in the future, and probably sooner than 10 years. With 170,000 cases per year and an unprecedented volume of lung cancer research, the lumping together of multiple, biologically disparate subsets becomes increasingly unwieldy.

A more precise, durable system might simply denote the 18 TNM subsets by numbers 0 through 17. Thus, carcinoma in situ would retain stage 0; T1N0M0 would become stage 1, and T2N0M0 would be stage 2 (instead of IB). The TNM listing on Table 3 of Mountain’s paper lends itself to this approach. Lung cancer treatment reports could be limited to a highly specific single lesion, such as T3N0M0 (stage 5), or a group of related lesions (say, T1N3M0+T2N3M0+T3N3M0+T4N3M0—stages 13 through 16), without “contaminating” the cohort with very different tumors (such as T4N0M0 lesions), as would occur with the current system and its seven stage IIIB subsets. Furthermore, simple numeric designations are concise, easily understood, and could easily be affixed with modifiers based on pathologic or genetic characteristics. For example, stage I tumors (T1N0M0) could be subdivided into lp53+ and lp53— if the effect of the p53 mutation was to be studied.

In conclusion, despite the considerable merits of the new system, it is cumbersome and onerous to remember for pulmonary trainees and practitioners who do not encounter numerous lung cancer patients on a daily basis. Worst of all, it has an intrinsically, time-limited usefulness. A simple numeric system would provide a more logical expression of the TNM system and prove more responsive to the changing clinical and research environment in the long run. Precise comparisons of treatments would be facilitated. In lung cancer staging the splitters should prevail over the lumpers.

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REFERENCES

1 Mountain CF. Revisions in the international system for staging lung cancer. Chest 1997; 111:1710-1717

Thoracic Tumors in Pregnant Women

To the Editor:

The case report by Abul-Khoudoud and colleagues in CHEST (September 1997)d was of particular interest to us. We have been concerned about the consequence of thoracic tumors in women during pregnancy for many years. An oral presentation was made at the third Pan-American Congress of the American College of Chest Physicians in Mexico City,

Table 1—Thoracic Tumor Complications During Pregnancy and Delivery*

<table>
<thead>
<tr>
<th>Age, yr</th>
<th>Symptoms or Delivery</th>
<th>Chest Radiograph</th>
<th>Operation</th>
<th>Diagnosis</th>
<th>Postoperative Complications</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Shock</td>
<td>C-section</td>
<td>Preop-faint, R chest mass, R chest opacified at operation</td>
<td>C-section, R thoracotomy with resection</td>
<td>Pedunculated mesothelioma</td>
<td>Long-term respirator</td>
</tr>
<tr>
<td>30</td>
<td>Progressive asthma</td>
<td>3rd</td>
<td>Tracheal mass</td>
<td>Bronchoscopy, C-section, tracheal resection</td>
<td>Mucoepidermoid bronchial adenoma</td>
<td>LLL infiltrate</td>
</tr>
<tr>
<td>29</td>
<td>Pain with dyspnea</td>
<td>Delivery</td>
<td>R postchest mass</td>
<td>R thoracotomy with resection</td>
<td>Pedunculated mesothelioma</td>
<td>None</td>
</tr>
<tr>
<td>23</td>
<td>Pain</td>
<td>3rd</td>
<td>Retrosternal mass</td>
<td>L thoracotomy with resection chest wall</td>
<td>Mediastinalleiomyosarcoma</td>
<td>Recurred, resected again</td>
</tr>
<tr>
<td>30</td>
<td>Mass neck</td>
<td>1st</td>
<td>Mediastinal adenopathy</td>
<td>Staging laparotomy, mantle radiation</td>
<td>Hodgkin's disease Stage II (nodular sclerosing)</td>
<td>None</td>
</tr>
<tr>
<td>26</td>
<td>Hemoptysis</td>
<td>3rd</td>
<td>LLL cyst</td>
<td>Segmentectomy, 3 weeks later, lobectomy</td>
<td>Bronchiolar carcinoma in cyst</td>
<td>None</td>
</tr>
<tr>
<td>30</td>
<td>Mass neck</td>
<td>3rd</td>
<td>Mediastinal adenopathy</td>
<td>Cervical node biopsy, C-section staging, laparotomy</td>
<td>Hodgkin's disease</td>
<td>None</td>
</tr>
<tr>
<td>38</td>
<td>Slight cough</td>
<td>Postpartum</td>
<td>Coin lesion, RUL</td>
<td>Segmentectomy, RUL lobectomy</td>
<td>Adenocarcinoma</td>
<td>None</td>
</tr>
</tbody>
</table>

* LW = living and well; LLL = left lower lung; RUL = right upper lung.
October 31-November 2, 1983. Because of the unusual combination of the occurrence of thoracic tumors and pregnancy, we reviewed our case load at that time and also the literature. We have seen a number of women between the age of 23 and 38 with tumors involving the chest. These are outlined in Table 1 with their symptomatology. Their presentations varied from mild cough to shock, and they were seen during the first and third trimesters, in the delivery room and in the immediate postpartum period. In all cases, a mass was identified on chest radiograph, either in the lung or in the mediastinum. Surgery included cervical node biopsy and staging laparotomy, right and left thoracotomy, a segmentectomy or lobectomy, as well as a cesarean section on an emergency basis and immediate tracheal resection. The diagnoses were those of: (1) carcinoma (adenocarcinoma, bronchiolar carcinoma); (2) Hodgkin’s lymphoma; (3) leiomyosarcoma; or (4) benign tumors (pedunculated mesothelioma and mucoepidermoid bronchial adenoma). Postoperative complications included long-term respiratory care in one patient, a pulmonary infiltrate in the emergency tracheal resection patient, and recurrence of the leiomyosarcoma, which required a repeat resection. Long-term results were excellent in both the mother and the child.

We thank the authors for presenting such an unusual and difficult situation. In each one of our patients, an ethical, as well as practical discussion was carried out regarding the approach in a pregnant individual or a patient with complications in the delivery room. Surgical intervention and appropriate therapy were initiated with excellent results, from our perspective. Thoracotomy, radiation, and chemotherapy may be utilized selectively in this group of difficult and uncommonly reported situations.

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Erratum

In “Pathophysiology of Cardiac Tamponade” by David H. Spodick, MD, DSc, FCCP (CHEST 1998; 113:1372–1378) the legends of Figures 1 and 2 contained an error. The legends referred to Dr. Spodick as editor of the book The Pericardium: A Comprehensive Textbook from which the figures were reproduced. Dr. Spodick was the sole author of the book, not the editor.