Does Primary Pulmonary Choriocarcinoma Really Exist?

To the Editor:

We read with interest the article by Tsai et al (March 2002), but several points make us doubtful about the diagnosis of primary pulmonary choriocarcinoma, as follows:

1. There is no comment concerning the technique (physical examination? ultrasonography? CT scan? MRI? other?) adopted to exclude for certain that the patient had no testicular lesion. Moreover, it is well known that the “burnt-out” phenomenon occurs in germinal tumors in general, and in choriocarcinoma in particular. Choriocarcinoma is likely to metastasize greatly prior to detection of the primary lesion, leaving only zones of scarring and hemosiderin-laden macrophages in the tests.

2. Chest radiographs and CT scanning displayed bilateral pulmonary involvement by ground-glass opacities and nodules, showing many clinicoradiologic similarities with the previously report by McGowan et al, who described a testicular choriocarcinoma plus sleep disordered breathing—in a small series of crime victims with PTSD [abstract]. Sleep 2001; 24(suppl):A120


Observation-Only Management of Inoperable Lung Cancer

Do Not Do That: A Loud and Clear Radiographic Point of View!

To the Editor:

We have read with interest the recent article in CHEST by McCarty et al (April 2002) on three different treatment options in 128 patients with early stage non-small cell lung cancer (NSCLC). Although the authors acknowledge the limitations of their retrospective study, which showed no advantage for radiation therapy (RT) over observation only, we believe that additional aspects need to be brought to the attention of the readership of the journal, so as to leave no doubts regarding treatment choice in this patient population. These aspects are as follows:

1. More information about differences between the treatment groups regarding various pretreatment characteristics should have been disclosed, principally regarding patients’ refusal to surgery (14 refusals in the observation-only group vs no refusal in RT group; reason for radiotherapy referral not specified in 7 patients in the RT group). This may have seriously imbalanced prognosis, since it was shown that patients’ refusals inversely correlate with the incidence of intercurrent deaths, which, on the other side, directly correlate with increasing age and pre-existing comorbid-

REFERENCES


is, inclusion of uninvolved ipsilateral hilum and/or ipsilateral
best results are actually those using some elective nodal RT, that
field in this patient population. Second, the studies achieving the
prospective randomized study evaluating the issue of optimal RT
approach in this disease. This is not so. First, there is not a single
has higher stages of the disease. Thus, any reliable comparison to
as evidenced by low-RT doses frequently used, and most likely
– 40% in T1N0 patients. 8 This should assure referring physicians
we believe, in technically operable but medically inoperable early
become one of our top priorities in the near future.

Finally, the authors state that local field RT is a standard RT
approach in this disease. This is not so. First, there is not a single
prospective randomized study evaluating the issue of optimal RT
held in this patient population. Second, the studies achieving the
best results are actually those using some elective nodal RT, that
is, inclusion of uninvolved ipsilateral hilum and/or ipsilateral mediatinum, 2–4 which can be seen as the radiotherapeutic equivalent of lobectomy.

Numerous studies have clearly documented the effectiveness
of RT alone in this disease, with median survival times of
> 30 months and a 5-year survival rate of > 30%, 2–7 going up to
40% in T1N0 patients. 8 This should assure referring physicians
that we can offer our patients a “best treatment approach” which,
we believe, in technically operable but medically inoperable early
stage NSCLC, is RT alone. We are opponents, not advocates, of
“therapeutic nihilism” in treating this disease and in this patient
population. As we have observed the increase in patient numbers
in recent years, discovery of successful treatment options must
become one of our top priorities in the near future.

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References

To the Editor:

Thank you very much for allowing me to comment. I would like
to take the opportunity to clarify some points raised in this
review.

1. With respect to the various pretreatment characteristics
between the groups, all patients at the Richard L. Roudebush
VA Medical Center are assessed in both pulmonary medicine and surgery departments prior to a treatment
decision. It often seems the case that these decisions occurred prior to patient presentation at the multidisci-
plinary chest conference attended by all the other services
involved in the delivery of care. Patients who refused surgical treatment were not usually seen by the radiation
therapy service to discuss this option.

All patients were staged according to the American Journal of Critical Care staging criteria by the multidisci-
plinary chest conference at the time of diagnosis and were
entered as such into the institutional tumor data base. Dr.
Jeremic raises an important point. Indeed, many of the
patients classified as early stage lung cancer did not reach
our service until their cancers had progressed to the point of
requiring palliation; therefore, our estimation of mortality
due to lung cancer for those who received no treatment
early in their disease is an underestimate of the total misery
resulting from observation.

2. Cause of death was obtained from the tumor registry that
recorded the International Classification of Diseases, Ninth
Revision code from death certificates. The detailed records of
these patients, including patterns of failure, would be
exceedingly hard to obtain. Indeed, a prospective study
would likely provide better and more comprehensive infor-
mation on patterns of failure and cause-specific survival, but
it is unlikely that any such study will ever be attempted. The
main point we can derive from our work is that many of
these patients died of their cancers, many required pallia-
tion by radiotherapy resulting from progression of their
early stage cancers and, in my opinion, observation or “best
supportive care” is not the best strategy for management of
these patients when radiotherapy can be delivered safely
and effectively.

Communications to the Editor