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REFERENCES


Is Bronchoscopy Dangerous in the Pretreatment Workup of Non-small Cell Lung Cancer Patients?

To the Editor:

We read the article by Nakajima et al1 on the possible negative impact of transbronchial lung biopsy (TBLB) on the postsurgical prognosis of non-small cell lung cancer (NSCLC). The authors conclude suggesting that “. . . a pathologic examination without preoperative bronchoscopy, but through intraoperative incisional biopsy followed by curative surgery, might be beneficial for patients with early-stage lung cancer.” We would like to comment on this.

The TNM staging system of lung cancer includes bronchoscopy in the pretreatment workup on the basis of scientifically well-proved data. Airway examination provides indispensable information on site and size of the tumor (T descriptor), as well as on the presence of synchronous lesions. Gasparini et al2 found synchronous endobronchial visible lesions in 72 of 570 patients (12.6%) being studied for bronchial visible lesions and such finding either contraindicated surgery or modified the therapeutic strategy in 35 patients (48.6%). Pierard et al3 submitted 43 NSCLC-operable patients to autofluorescence chial visible lesions in 72 of 570 patients (12.6%) being studied for bronchial visible lesions and such finding either contraindicated surgery or modified the therapeutic strategy in 35 patients (48.6%).

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The TNM staging system of lung cancer includes bronchoscopy in the pretreatment workup on the basis of scientifically well-proved data. Airway examination provides indispensable information on site and size of the tumor (T descriptor), as well as on the presence of synchronous lesions. Gasparini et al2 found synchronous endobronchial visible lesions in 72 of 570 patients (12.6%) being studied for peripheral lesions, and such finding either contraindicated surgery or modified the therapeutic strategy in 35 patients (48.6%). Pierard et al3 submitted 43 NSCLC-operable patients to autofluorescence bronchoscopy and demonstrated synchronous carcinomas in situ or dysplasias in 8 patients (18.6%). Airway examination proves also extremely helpful to identify candidates for sleeve resection of the main bronchus or carina.

Bronchoscopy may also be useful in the definition of the N descriptor through transbronchial needle aspiration (TBNA), which precludes the need for unnecessary diagnostic or therapeutic surgical procedures when it shows malignant cells, due to its extremely high specificity.4,5 A systematic review6 of 910 TBNA procedures suggested sensitivity and specificity as high as 76% and 96%, respectively. A more recent meta-analysis7 showed that the sensitivity is much lower than previously thought in populations with low prevalence of lymph node metastasis, but it confirmed that the method is highly specific.

In conclusion, pretreatment workup of NSCLC lacking bronchoscopy is incomplete and inaccurate, and it may cause inappropiate therapeutic planning. As for the diagnosis of peripheral lesions, there is no evidence in the literature of tumor implantation in the airway caused by TBLB, so far, as the authors state, and we look forward to a prospective randomized trial to reliably assess the effect of TBLB on the postsurgical prognosis of NSCLC.

Complete Response Following Preoperative Chemotherapy for Resectable Non-small Cell Lung Cancer

To the Editor:

We read with great interest the recent study by Milleron et al1 on the evaluation of complete response (CR) by clinical investigators and an evaluation committee (EC) in patients treated using neoadjuvant chemotherapy for non-small cell lung cancer (NSCLC). The study was carried out using the database of the well-known French randomized trial2 and showed a low sensitivity of CR diagnosis by investigators (31.6%) and EC (15.8%). Specificity, positive and negative predictive values, and accuracy were very high for both investigators and EC, leading to the conclusion that investigator assessment was highly predictive of pathologic CR. Moreover, the study showed that clinical CT scan-based assessment, for both investigators or EC, underestimated the frequency of CR after induction chemotherapy in resected NSCLC.

This study has some methodologic biases that may severely weaken the reported message: (1) a lack of homogeneity in clinical staging: mediastinoscopy or mediastinotomy was not routinely used in IIIA patients to confirm histologic N2 disease before enrolment onto the trial; (2) absence of a homogeneous surgical treatment: in the original article,2 a complete lymph node dissection was performed in 59 patients (40.4%) of the preoperative chemotherapy arm; a lymph node sampling in 56 patients (38.4%), and 31 patients (21.2%) received neither a dissection nor a sampling (calculation based on data from Table 3 of Depierre et al3). Therefore, limitation in their staging technique