connective tissue diseases, and they showed a median of 30% of lymphocytes in BALF. Additionally, 58% of these lymphocytes in BALF showed MALT1 gene rearrangements in the patients with MALT lymphoma. These results suggest that BALF lymphocytes in patients with MALT lymphoma include tumor cells (B cells) and reactive lymphocytes (possibly T cells), and our results were consistent with the report by Borie et al.

We agree with Dr. Borie and colleagues that it is necessary to confirm the utility of BALF for the diagnosis of pulmonary MALT lymphoma in a larger prospective study. MALT1 gene rearrangements are not always positive in patients with pulmonary MALT lymphoma, and the absence of the rearrangements does not exclude the diagnosis of pulmonary MALT lymphoma. We, therefore, think that a combination of detecting MALT1 gene rearrangements and other modalities, such as the detection of other chromosomal translocations, analyses of surface markers, and the detection of clonality in BALF lymphocytes may, thus, have a greater sensitivity and specificity for the diagnosis of pulmonary MALT lymphoma.

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Treatment of Peripheral Lung Tumors Arising After a Prior Pneumonectomy

To the Editor:

We read with interest the report from Yamauchi et al1 in an issue of CHEST (December 2011) on the use of percutaneous cryoablation to manage lung tumors arising in the contralateral lung postpneumonectomy. The authors indicated they were unaware of reported outcomes for the use of stereotactic radiotherapy (SRT) in this group of patients. In 2009, we reported such outcomes for 15 patients presenting with a new primary lung cancer after prior pneumonectomy;2 One-half of these patients had severe COPD, with maximum tumor diameters ranging between 8 and 35 mm and no local failures after a median follow-up of 16.5 months (range, 4-55 months). In contrast to percutaneous cryoablation, SRT is performed as an outpatient treatment, typically in a few minutes using modern delivery units and with high accuracy, as on-table CT scans permit verification of target position prior to delivery.3 Additionally, SRT delivery does not always require percutaneous insertion of fiducial markers, eliminating the accompanying risk of morbidity and mortality in patients with a single lung.

The authors previously reported a 60% incidence of pneumothorax, 17% of which required chest tube drainage, and 70% and 35% incidence of pleural effusion and hemoptysis, respectively, after 193 sessions of percutaneous cryoablation.4 Similarly, a population-based analysis of complications following transthoracic lung biopsy of peripheral lung nodules reported the risk for any pneumothorax was 15.0% (95% CI, 14.0%-16.0%), with a 6.6% (95% CI, 6.0%-7.2%) overall risk of chest tube insertion.5 Because local control rates in excess of 90% have been reported for patients undergoing SRT in prospective multicenter settings,6 we suggest that SRT should be offered as a standard treatment option in all patients presenting with a new lung tumor postpneumonectomy. In patients who are at a lower risk of complications arising from pneumothorax, we would agree that comparative trials among modalities such as cryoablation, radiofrequency ablation, and SRT merit study.

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