Letter to the Editor

Video-assisted thoracoscopic surgery in a patient with pulmonic and endobronchial metastatic disease from a colonic carcinoma


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In a recent publication, Landreneau and colleagues [1] established several patient selection criteria for the resection of pulmonary metastatic lesions by means of video-assisted thoracoscopic surgery (VATS) in subjects suffering from colorectal carcinoma and, also in this article, they rejected for metastatectomy those patients with endobronchial metastases. We must say that we respectfully disagree with these authors in this particular issue and we would like point out some special circumstances regarding this subject.

We would like to make a comment on the case of a patient with a single pulmonary metastasis, treated with VATS, in whom a single endobronchial metastasis was found in the preoperative bronchoscopy, which was also treated locally.

A 69-year-old woman was diagnosed with carcinoma of the sigmoid colon and was treated with surgery, chemotherapy and radiotherapy. At 54 months, a routine follow-up chest radiography disclosed a single coin lesion in the right lower pulmonary lobe. A thoraco-abdominal CT scan confirmed the existence of a 3 cm nodular lesion in the lateral–basal segment of the right lower pulmonary lobe, with no mediastinal lymphadenopathies. A transthoracic fine needle biopsy of this lesion was highly suspicious of metastasis. There was no evidence of recurrence of the primary tumour and the serum level of carcinoembryonic antigen (CEA) was 1.6 μg/l. With the diagnosis of single pulmonary metastasis of colonic carcinoma, the patient underwent metastatectomy with VATS. An intraoperative bronchoscopy was performed which revealed a single 1 mm lesion on the anterior carinal wall. This lesion was biopsied intraoperatively (the histology was reported as bronchial mucosa with squamous metaplasia and submucosal adenocarcinomatous infiltration, consistent with the diagnosis previously established). A modified segmentectomy was performed and the diagnosis of metastasis (with tumour-free resection margins) was confirmed in the resected specimen. The endobronchial affected area was treated locally with a ND-YAG endoscopic laser. At 5 months follow-up, no tumour recurrence could be demonstrated, either with bronchial biopsy or with thoracic CT scan.

There are several accepted premises that patients must fulfil before undergoing surgery for metastatic lung disease [2]. With the introduction of VATS, these premises still apply [3], but the patients may benefit from a less aggressive technique. Other factors, such as the disease-free interval, location of metastases, type of resection or primary tumour staging, have not been demonstrated to influence post-surgery survival [4].

There are some authors who do not regard the resection of lung metastases further to hepatic metastatectomy as a contraindication in patients affected by colonic carcinoma [5]. We believe that, although the presence of endobronchial metastases (in the same manner as liver metastases) implies a worse prognosis in these patients as it indicates tumour spread, surgery must be considered since it is the only possible curative method. Our experience herein reported illustrates how local treatment of both metastatic lesions allowed the patient to remain disease-free to this date.

References


[2] The International Registry of Lung Metastases. Long-term results of

