5. Follow-up: the size, shape and nature of the wall of a traumatic cyst changes in a relatively short period unlike other kinds of cystic or cavitary lesions [4].

In conclusion, there are so many different characteristic points in these two entities that the differential diagnosis between them is easily evident.

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Letter to the Editor

Is compromising on surgical margins in tracheal resection for cancer justified?

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We read with interest the article by Hazama et al. [1] on a retrospective analysis of 20 cases of primary tracheal cancer. We take exception to the recommendation that tension reduction should take precedence over surgical margins during tracheal resections for cancer and the implied suggestion that postoperative radiotherapy is expendable in many cases, even with positive margins. Though we agree that anastomotic tension is disastrous and should be avoided, implying that resection margins can be compromised is a dangerous suggestion. The authors base their conclusion on the fact that none of their five patients with positive resection margins recurred locally, though only three of these patients received postoperative radiotherapy. We believe that five patients are too few to base such a dramatic recommendation on. It is also to be noted that all these five patients had adenoid cystic carcinoma, which has better biological behaviour than other tracheal cancers. It is well known that margin positivity in adenoid cystic carcinoma is far less sinister than in squamous carcinomas [2]. In Grillo’s series, four of the five patients with positive invasive margins in squamous carcinomas of the trachea died of the disease. Extrapolating the results of five patients with adenoid cystic carcinoma to all tracheal cancers is naive at best and dangerous at worst. Grillo has conclusively proven that tracheal resections as long as 6.5 cm can be safely performed by adequate pretracheal mobilization, right hilar mobilization and cervical flexion [3]. As seen in the authors’ own series (mean length, 4.0 cm, range, 2.5–4.8 cm), it is very rare that more extensive resections are required. Extensive tracheal reconstructions, when necessary, need to be performed in centers specializing in this type of surgery.

Both squamous and adenoid cystic carcinomas are sensitive to radiotherapy and it appears unwise to withhold postoperative radiotherapy in these patients. As noted by the authors themselves and by others [2], margins obtained at tracheal resections are usually narrow and routine postoperative radiotherapy is advisable, even in patients with negative surgical margins and negative lymph nodes [2]. There have not been (and probably will not be, given the rarity of the disease) any randomized trials to assess the value of adjuvant radiotherapy, but consolidating one local treatment (surgery) with another (radiotherapy) seems logical in a disease where the consequences of local recurrence are uniformly fatal. We therefore disagree with the authors on two counts – firstly, that serious effort needs to be made to achieve negative resection margins, especially in squamous carcinomas and secondly, that postoperative radiotherapy should be recommended routinely to all patients.

References

Indeed we agree to pursue pathological negative margin in performing surgical treatment for malignant diseases, but we should not stick around this concept in managing tracheal malignant tumors.

Postoperative leakage at anastomotic site is not fatal in operation for digestive organ but for trachea. In addition, postoperative radiotherapy has been reported to be effective against residual malignant cells [1, 2], we proposed that tension reduction of the anastomosis should take precedence over surgical margin [3]. But this is not always suitable in managing tracheal squamous cell carcinoma representing high grade malignant behavior but in adenoidcystic carcinoma with low grade malignancy, as Dr Pramesh suggested.

Of course, we performed extensive efforts to reduce tension at anastomotic site, but we should refer to Dr Grillo’s latest data about the length of cut specimen as long as 6.5 cm [4], as Dr Pramesh had mentioned, and reconfirm surgical procedures and postoperative management to decrease the tension.

Though we have also considered postoperative radiotherapy effective for tracheal malignant tumors, all of the patients did not undergo this adjuvant therapy. Since we did not have common therapeutic strategy for this rare malignant disease, various remedial plans were applied in many hospitals.

I also agree that extensive tracheal surgery should be performed in selected medical centers.

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