Reply to Johnson

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We thank Dr Johnson for her thoughtful comments regarding our review on the current surgical management of bronchioloalveolar carcinoma (BAC) [1]. She raises some pertinent issues to be addressed.

Regarding lung transplantation, studies by Garver and Zorn probably share some redundant patients, thus decreasing the real number of available transplant recipients with this condition. As we highlighted in the manuscript, we do agree that lung transplantation is an important and valuable treatment option in those patients with a progressive and bilateral disease, without evidence of distant metastases. However, molecular analysis of observed cases with graft recurrence performed by Garver is of concern. We think that further efforts, especially with molecular characterization of BAC, will be necessary before considering lung transplantation for BAC patients as a routine treatment.

The surgical option consisting of lung-sparing resection is really attractive regarding the propensity of multifocal recurrence in this disease, as recently emphasized by Nakata and colleagues [2]. However, there are still some matters of concern: (i) Is limited resection for 1 cm or less pure BAC (i.e. noninvasive carcinoma in the revised World Health Organization (WHO) classification) valid? and (ii) How to predict preoperatively the pure BAC nature of such a small sized pulmonary nodule? There is now growing evidence in the literature to answer positively to the first question [3,4]. The second issue is not clear. Indeed, insurance of noninvasiveness can only be given by microscopic examination of the operative specimen. However, CT scan findings showing ground glass opacity (GGO) seem highly and predominantly correlated with a pure BAC histology and preliminary results using this criteria to select candidates for limited lung resections are really encouraging [2,5]. To date, limited resections should be restricted to small GGO and avoided in the other cases in the absence of any comparative data with the standard of treatment (i.e. lobectomy and pneumonectomy).

To conclude, changes in the WHO classification makes the interpretation of several previous studies questionable and opens more questions on the surgical management of BAC than it resolves.

References


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