Letter to the Editor
Pulmonary resection in octogenarians

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The experience of Matsuoka et al. [1] with resections for lung cancer in octogenarians (n = 40) was characterised by 20% non-lethal complications (n = 8), 40% lobectomies (n = 16), 60% segmentectomies and wedge (n = 12 each), no pneumonectomy. There were 22 adenocarcinomas (55%), 11 squamous (27.5%), 4 large-cell (10%), 2 adenosquamous (5%), 1 neuroendocrine (2.5%) cell carcinomas and essentially pStage I disease (n = 35, 87.5%; pStage II n = 3, 7.5% and III n = 2, 5%); actuarial 5-year survival was 56.9%. These good results were clearly attributable to their case selection, as stressed by Shanmugam et al. [2] who considered it fortunate that no patient required a pneumonectomy and wondered whether it was worth operating on the octogenarians with N2 malignant lymphadenopathy.

Between 1984 and 2003, the authors operated on 66 octogenarians (curative resection with mediastinal lymphadenectomy): pneumonectomy n = 23 (34.8%), lobectomy n = 42 (65.6%) and segmentectomy n = 1. Postoperative complications (1 month or same hospital stay) was 31.8% (n = 21), including 7.6% deaths (n = 5): pneumonectomy 8.7% (2/23) and lobectomy 7.1% (3/42). There were 22 adenocarcinomas (30.3%), 34 squamous (51.5%), 6 large-cell (9.1%), 1 adenosquamous (1.5%), 5 neuroendocrine (7.6%) cell carcinomas. pStage I was 54.5% (n = 36), pStage II 19.7% (n = 13) and Stage III 25.8% (n = 17, of which N2 = 13 or 20%). Complications and postoperative deaths by stage were, respectively, Stage I 36.1% (13/36) including two deaths (5.5%), Stage II 30.8% (4/13) one death (7.7%), Stage III 23.5% (4/17) two deaths (11.8%) (NS). The whole series actuarial 5-year survival rate was 29.1% (median 26 months): Stage I 40.6% (median 42); Stage II 36.1% (median 26), Stage III 0% (median 11 months) (p = 0.0040).

This short series permits to answer Shanmugam et al. ’s [2] question by confirming that there is no surgery benefit for N2 octogenarians. It may also suggest explanations for Matsuoka et al. ’s [1] reply wondering why the ratio of pneumonectomy was so high in Europe, by illustrating a not so strict patients selection while taking care to preserve the best risk-benefits balance, and by also illustrating a well-known histologic pattern difference [3], which is more squamous cell carcinomas than adenocarcinomas in Europe, (as in authors’ series, respectively 51.5% and 30.3% versus 27.5% and 55%, p = 0.026), and which correlates with more proximal than peripheral lung cancers.

References


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Reply to the Letter to the Editor
Reply to Riquet et al.

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My coauthors and I thank Dr Riquet for his suggestive comment on our report [1,2]. I agree with your opinion that our good results were clearly attributable to a strict patients selection and multitudes of peripheral type adenocarcinomas. Histologic pattern difference between Japan and Europe is an interesting and considerable issue [3]. It is understandable that a high proportion of central type squamous cell carcinomas boost the number of pneumonectomy. However we believe that pneumonectomy is a disease in itself and should be avoided at all costs because of the long-term complications that are sometimes associated with pneumonectomy but seldom seen after lobectomy or sleeve lobectomy. That is, the so-called postpneumonectomy syndrome presenting as late pulmonary hypertension or respiratory failure [4]. In our series, four octogenarians (10% of all cases, 25% of lobectomies) were performed sleeve lobectomy with bronchoplasty to avoid pneumonectomy, and had no major complication. We believe that sleeve lobectomy should be applied whenever possible even in octogenarians.

References


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