When they are isolated often the pleural effusion is absent and, after a careful exploration of the pleural cavity, a single implant can be safely removed. Very recently we found a case of bilateral pleural implants 5 year from the resection of an invasive thymoma; we decided to treat them with staged procedures. On the left we removed multiple implants and added hyperthermic intrapleural chemotherapy, on the right we removed a single implant by VATS.

Furthermore, hyperthermic intrapleural chemotherapy is also feasible by a VATS approach, as already described [5] and personally performed for a huge stage IVA thymoma in a neoadjuvant setting.

As emphasized [1] it is unlikely that a randomized study will ever be performed to determine optimal treatment of pleural recurrences of thymoma; as a consequence every personal, even minimum experience is welcome in order to understand and improve the treatment of such rare situations. Limiting surgical trauma in patients with recurrent thymic disease and myasthenia, who might undergo iterative resections for subsequent pleural recurrences, is an important end-point and the efforts of Heyman and Van Schil of performing a pleural implant resection by VATS should be congratulated.

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Reply to the Letter to the Editor

Reply to Heyman and Van Schil

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We thank Heyman and Van Schil for their interest and added experience on the issue of surgical treatment of pleural recurrence of thymoma [1,2]. Such recurrences are rare and very rarely appear isolated. However with a strict follow-up by means of CT we are finding some cases [3,4].

Letter to the Editor

Remediastinoscopy: a dangerous tool?

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We read with great interest the review of Van Schil and Dewaele on remediastinoscopy [1]. We agree that cyto-
histological proof of persistent N2-disease after induction treatment is recommended.

In Table 3, they report the literature results of mediastinoscopy after induction therapy. It is claimed that good results with mediastinoscopy can be obtained in four out of the five centres that published their experience [1]. They report that the sensitivity of mediastinoscopy in the study of Pitz et al. was 71.4%. The sensitivity is however not reported in that article [2] and it is not clear to us how it was calculated. In 6 of the 15 patients no biopsies or incomplete biopsies were obtained due to fibrosis or adhesions. Of all patients with an adequate repeat mediastinoscopy (n = 9), two had positive nodes. Seven biopsies showed negative results. In two patients this proved to be false negative at thoracotomy. When we calculate the sensitivity (true positive/true positive + false negative) we obtain a sensitivity of 50%. The authors [2] conclude: 'the results of repeat mediastinoscopy are disappointing and proved to be a not so effective restaging tool because of the high number of incomplete procedures and because it yields false negative results.'

In a prospective study we evaluated the accuracy of PET-CT and mediastinoscopy in restaging after mediastinoscopy proven N2 disease. Mediastinoscopy, although technically feasible, had a very low sensitivity [3]. It is suggested by Van Schil that a possible explanation for the discrepancy could be the use of a videomediastinoscope because that videomediastinoscope is larger and the three-dimensional view is lost.

Videomediastinoscopy has internationally been accepted to result in improved visualisation and accuracy of mediastinal staging. We use the Lerut-videomediastinoscope (Storz®). At the tip, the external diameter of this videomediastinoscope is only 1 mm larger in height and breadth, compared to the regular mediastinoscope. Such small differences cannot be responsible for the differences in sensitivity [3]. This assumption clearly lacks scientific evidence. Moreover, a view through the scope always remains possible providing a three-dimensional view whenever judged necessary.

The aim of mediastinoscopy in staging of potentially resectable NSCLC is to have a full mapping of all mediastinal lymph nodes (LNs). In contrast to all other studies, our study was a prospective study reporting the number of LN levels biopsied during the first mediastinoscopy. In one of the retrospective studies, one third of the patients had more LN levels involved at mediastinoscopy compared to the initial mediastinoscopy suggesting that at initial mediastinoscopy not all LN levels were biopsied [4]. We believe that the lower sensitivity in our study is related to more adhesions and fibrosis, which is most likely the result of a more complete first mediastinoscopy.

So basically, the good results with mediastinoscopy are only obtained in three very experienced centres and are based on retrospective data. Moreover, in a combined series, 3 out of 104 patients developed severe bleeding during mediastinoscopy resulting in one mortality and one thoracotomy with pneumonectomy [5]. One can assume, if this is occurring in high volume expert centres that further diffusion in centres with less experience may result in even more catastrophes.

It seems to us that a thorough mediastinoscopy can only be performed once safely. Therefore, we do not believe that mediastinoscopy is a valuable tool for restaging after induction therapy. In an area of PET or PET-CT, endoscopic fine needle aspiration, we have to rethink staging and restaging algorithms.

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Reply to the Letter to the Editor

Reply to De Leyn and Lerut
Mediastinoscopy and repeat mediastinoscopy: still useful tools in experienced hands!

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With the advent of functional imaging modalities and minimally invasive endoscopic techniques, staging and restaging of locally advanced lung cancer remains a controversial topic as can be appreciated by the comments of De Leyn and Lerut [1]. The specific role of each modality has not been decided and the pendulum is still swinging from one side to the other, also depending on the experience a centre has with a specific technique.

Regarding the accuracy of mediastinoscopy (reM5) De Leyn and Lerut have suggested several times that we are not