years undergoing lung resection and SMLND to younger patients, found no differences in hospital stay, major morbidity or operative mortality. In their review on mediastinal lymphadenectomy, Zhong and colleagues concluded that current evidence favors better survival with SMLND and that complete mediastinal lymphadenectomy is the core component of the multidisciplinary treatment of lung cancer [5].

Surgical treatment should not be denied to elderly patients due to age; long-term survival of elderly patients with early-stage NSCLC treated by anatomical pulmonary resection is comparable to that of younger patients. We see no reason not to offer elderly patients potentially curative treatment in the form of radical pulmonary resection with complete mediastinal lymphadenectomy.

References


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Reply to the Letter to the Editor

Reply to Jiwnani et al

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We thank Jiwnani et al. [1] for their interest in our article [2], and appreciate the editor for giving us the opportunity to reply. We fundamentally agree with their opinion that surgical treatment should not be denied to elderly patients only because of chronological age. On the other hand, it is also true that the elderly are generally more sensitive to the invasiveness of an operation as compared with the younger patients. Therefore, surgeons should always consider less invasive but sufficiently effective procedures when performing surgery for elderly patients. We believe that such an attitude is not contrary to standard surgical procedures, but rather quite reasonable in this era of aging patients. In addition, we would like to note that we demonstrated the possibility of avoidance of radical lymphadenectomy in the operation for elderly lung-cancer patients, which did not deny the radical operation in such patients.

Their argument that retrospective studies have inherent drawbacks related to potential selection bias and confounding factors is quite valid. As mentioned in our article, definitive evidence can only be demonstrated from the results of randomized controlled trials. Nevertheless, we again advocate a retrospective study analyzed carefully could supply encouraging data for bringing in a new proper procedure.

As Jiwnani et al. stated in their letter, the non-radical lymphadenectomy (NLA) group in our study looked to include patients with higher age, earlier stage, and a less-invasive surgical strategy, as noted in the table showing patient characteristics. However, this is why we proposed propensity score (PS) analysis to reduce bias in treatment selection and compared the effects of each procedure between better-balanced two groups. To compare the effects of two different surgical treatment procedures, PS must be calculated based only on the preoperative data, which is why we did not show the pathological stages or other postoperative information in the table showing patient characteristics.

After stratification based on PS, patients in the same stratum could be considered to have the same probability of undergoing a radical lymphadenectomy (RLA) or NLA procedure. We checked the validity of this method and found that the background characteristics in each PS quartile were equally distributed between the two groups, as shown in Table 3 of our study. This PS analysis method is now recognized as an established statistical technique for retrospective studies, and can compensate for differences in the heterogeneity of two groups. We believe that our results and conclusions can be satisfied statistically and also practically.

We look forward to further studies of the impact of RLA as well as other investigations of appropriate treatments for elderly lung-cancer patients.

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