for such recurrent patients, since there were no major postoperative complications and patients with a recurrence after a pulmonary metastasectomy showed long-term survival.

5. Conclusions

The low mortality rate and, at present, the lack of an established effective systemic chemotherapy are thus considered to justify an aggressive approach to a surgical resection. Good surgical candidates for pulmonary resection are those showing a prethoracotomy normal CEA level and resection. Good surgical candidates for pulmonary resection established effective systemic chemotherapy are thus considered to be an effective and safe treatment based on our above described.

References


eComment: The role of lymph node dissection in pulmonary resection for metastases from colorectal cancer

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We read with great interest the article by Maeda et al. concerning pulmonary resection for metastases from colorectal cancer [1].

The role of lymph node dissection in pulmonary metastasectomy from extrapulmonary malignancies is a debatable issue. Few articles are written about the need of lymphadenectomy accompanying metastasectomy [2, 3]. Performing systematic lymph node dissection Loehe et al. found unexpected metastases in nine patients (14.3%) resulting in a worse survival, which was not significant. Welter et al. found a significant prognostic difference in patients with or without lymph node involvement, having performed a sampling only in case of suspicious enlarged nodes [4]. Saito et al. emphasized the need for a prospective study to investigate whether lymph node dissection improves the survival with pulmonary metastases from colorectal carcinoma [5]. Okumura et al. reported that systematic dissection of involved mediastinal nodes is not helpful in controlling the systemic disease [2].

Our policy is to do lymph node sampling during metastasectomy and not a systemic lymph node dissection. According to our institute’s experience, mediastinal nodal involvement has definitely a negative impact on survival. It is well established that lung metastases are predecessors of further systemic spread. So, our policy is to offer adjuvant chemotherapy in all cases, even though the resected metastasis is solitary and preoperative biomarkers are within normal range.

References


