We thank Dr Baisi and colleagues for their interest and kind comments. The authors fully endorse all the assessments made by Dr Baisi and colleagues [1]. We consider the lung sparing techniques (regular or extended sleeve lobectomy) [2] as the only way to obtain an increase in survival after neoadjuvant therapy in central tumours owing to their ability to reduce complications and mortality. It is worthwhile, beyond doubt, to use any surgical technique that spares the parenchyma and avoids the complications related to pneumonectomy.

With regard to the preoperative radiotherapy doses, our protocol currently includes only concurrent chemoradiotherapy (60 Gy) for mediastinal sterilization. However, we do not prohibit the performance of this surgery in second opinion patients coming from other units, with lower radiation doses or even after the classical timing window (8 weeks) [3]. In clinical practice, we restage the mediastinum after chemoradiotherapy by non-invasive methods (chest CT scan or positron emission tomography–CT) and selectively using other invasive techniques (endobronchial ultrasound, endoscopic ultrasonound-guided fine-needle aspiration or mediastinoscopy). We pay great attention to ruling out distant metastases after induction, expending as much time and resources as necessary, because, in our opinion, the induction therapy also ‘naturally’ selects patients who have an extremely poor prognosis (e.g. occult distant metastases or progression despite treatment). Among the reasons for this protocol, we have found that the oncologist requests surgical treatment if there is a tumour response in the absence of prohibitive risk (even with one positive station); a low surgical mortality rate is achieved in experienced institutions after chemoradiotherapy (<3%); and there is a reasonably good quality of life after surgery [4] following pulmonary resection rather than pneumonectomy.

REFERENCES