Reply to Baisi et al.

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Keywords: Lung cancer • Mediastinal lymph node dissection • Micrometastasis • Skip metastasis

We would like to thank Baisi et al. [1] for their interest in our paper. We reported the results of bilateral thoracoscopic medias- tinal nodal dissection compared with unilateral dissection in left-sided non-small-cell lung cancer (NSCLC) [2]. The prognosis of Stage I NSCLC is unsatisfactory, probably due to the high incidence of right paratracheal node involvement in left lung cancer [3] and residual occult micrometastases. Baisi et al. recom- mended sampling of the right paratracheal nodes for left-sided NSCLC by mediastinoscopy. This is one of the options for explo- ring the staging meticulously and is minimally invasive.

The aim of our procedure is not only accurate staging, but also the investigation of the possibility of contributing to the prognosis under bilateral mediastinal clearance.

Surprisingly, we could find a high incidence of skip microme- tastases to the contralateral mediastinum and increased the stage. These results may be due to the high sensitivity of cytokeratin-19 reverse transcriptase-polymerase chain reaction methods. However, our findings of contralateral skip micrometastases without pathological ipsilateral nodal involvement may suggest the lack of predictive factors of contramediastinal staging. As only one pathological N2 case showed molecular N3 in our study, analysis of more N2 patients may resolve this issue. Although molecular staging remains controversial and is not widespread, this method enables us to achieve accurate staging and may improve the prognosis of contralateral single-station micrometastasis.

Although Izbicki et al. [4] reported that the prognosis of pathological N0/N1 with micrometastases showed results comparable with pathological N2 metastases, the number of patients was small and it was premature to draw any definitive conclusions. Furthermore, Nosotti et al. [5] reported a worse prognosis in patients with mediastinal micrometastases. However, micrometastases in our study included isolated tumour cells defined by the Union International for Cancer Control criteria, and the biolog- ical behaviour should differ between these two criteria. Since the prognosis should be related to the heterogeneity of the patient population in a relatively homogeneous background, the analysis of a greater number of propensity-matched patients may elucidate the prognostic value of micrometastases.

As the limitations of our study were a short follow-up period, a small number of patients and a lack of adjuvant chemotherapy, except in 1 pN2 patient, it was not possible to draw any conclusions on the prognosis in the bilateral group compared with that in the unilateral group. However, these results may suggest the improved survival of patients with single skip micrometastasis to the contralat- eral mediastinum by bilateral dissection. All micrometastases in our study consisted of a single station and may contribute to better sur- vival since single-station metastasis is a favourable prognostic factor of the N2 group [6]. If thoracoscopic bilateral node dissection is applied to clinical N0 patients because of acceptable complications, N3 skip micrometastases should not be a contraindication of surgery and better prognosis could be expected.

In conclusion, as a more efficient preoperative detection system of N3 micrometastases is not available, bilateral node dis- section by thoracoscopy may be a powerful tool for accurate staging and one of the options for a therapeutic strategy.

REFERENCES