Accurate and safe mediastinal restaging by combined endobronchial and endoscopic ultrasound-guided needle aspiration performed by single ultrasound bronchoscope†

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Introduction

Real-time endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) and endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) are actually well introduced methods of biopsy of mediastinal nodes [1–4]. A combined ultrasound-needle aspiration approach (CUS-NA) has been presented only in few publications in non-small-cell lung cancer (NSCLC) staging as an alternative to mediastinoscopy and in none in restaging after induction therapy exclusively [5–10]. The CUS-NA technique enables more accurate assessment of the mediastinum and increases the diagnostic yield, but both methods are still not being commonly used in one session. Both techniques are highly complementary, but the main disadvantage is the limited reach of EUS-FNA especially for pulmonologists and thoracic surgeons. Only dedicated endoscopists well experienced in bronchoscopy and oesophagoscopy may perform both

Methods: In a consecutive group of NSCLC patients with pathologically confirmed N2 disease (clinical stage IIIa and IIIb) who underwent induction chemotherapy, CUSb-NA was performed. All of the patients with negative or suspected for metastases (uncertain) diagnosed by endoscopy underwent subsequently transcervical extended mediastinal lymphadenectomy (TEMLA) as a confirmatory test.

Results: From January 2009 to December 2012, 106 patients met the inclusion criteria and underwent restaging CUSb-NA under mild sedation, in whom 286 (mean 2.7, range 2–5) lymph node stations were biopsied, 127 (mean 1.2, range 1–3) by EBUS-transbronchial needle aspiration (TBNA) and 159 (mean 1.5, range 1–4) by EUS-fine needle aspiration (FNA). The CUSb-NA revealed metastatic lymph node involvement in 37/106 patients (34.9%). In 69 (65.1%) patients with negative and uncertain CUSb-NA in 4 (3.8%) out of them, who underwent subsequent TEMLA metastatic nodes were found in 18 patients (17.0%) and there were single lymph nodes found only in one mediastinal station (minimal N2) in 10 (9.4%) out of them. False-positive results were found in 2 (1.9%) patients. In 9 (8.5%) patients CUSb-NA occurred to be false negative in Stations 2R and 4R (only accessible for EBUS), exclusively in small nodes and in 4 (3.8%) patients in Station 5—not accessible for CUSb-NA.

Conclusions: The CUSb-NA is a reasonable and safe technique in mediastinal restaging in NSCLC patients after induction therapy. Following our data, in patients with negative result of CUSb-NA, a surgical restaging of the mediastinum should be considered.

Keywords: Combined ultrasound-needle aspiration · Mediastinum · Non-small-cell lung cancer · Restaging

INTRODUCTION

Combined ultrasound-needle aspiration approach (CUS-NA) has been...
endoscopies as one procedure. In 2010, Herth et al. [11] and Bin et al. [12] introduced the combined ultrasound method by use of a single scope (CUSb) in NSCLC staging. In this variation, EBUS and EUS are performed using the same ultrasound bronchoscope. Although it allows imaging and biopsy of the left adrenal gland or liver metastases only in some patients, it is sufficiently for mediastinal staging. Reduced length of time of the procedure and lower hospital costs are the major advantages of CUSb approach comparing with CUS [13].

A mediastinal restaging after induction therapy is still a difficult and controversial issue. A discussion of the real diagnostic yield and utility of biotic techniques in the NSCLC restaging is still open.

There are currently no accepted standards regarding mediastinal restaging, and many strategies, based on radiological, minimally invasive and surgical techniques are advocated [14]. According to the recent European Society of Thoracic Surgeons’ and American College of Chest Physicians’ guidelines, minimally invasive procedures, including EBUS-TBNA and EUS-FNA, may be alternatively used, but mediastinoscopy or remediatioscopy should be preferably reserved for restaging [14–17].

**MATERIALS AND METHODS**

**Clinical question**

Is CUSb-NA an accurate and safe method in the NSCLC restaging after induction therapy?

What is the real sensitivity, specificity, accuracy, positive predictive value (PPV) and negative predictive value (NPV) of CUSb-NA in the NSCLC restaging, assessed using the bilateral mediastinal lymphadenectomy as the confirmatory test?

**Design**

This was a single-centre, prospective, cohort diagnostic study. The study was approved by the institutional ethic committee. No potential conflicts of interest are to report.

**Location**

Department of Thoracic Surgery and Endoscopy Unit, Pulmonary Hospital, Zakopane, Poland.

**Patients**

Inclusion criteria: (i) 4 years of period study, (ii) group of consecutive NSCLC patients in clinical stage IIIA–IIIB (in Stage IIIB either included N3 or T4N2 patients) confirmed only by EBUS-TBNA, EUS-FNA, CUS-NA or CUSb-NA, (iii) after 3–5 series of induction therapy (cis-platin + vinorelbine), (iv) enlarged or normal mediastinal lymph nodes on CT scans—defined by radiologists as having stable disease or partial response after induction therapy and (v) general condition enabling appropriate pulmonary resection.

Exclusion criteria: (i) no response after induction therapy—a progression of radiological or endobronchial lesions and (ii) lack of patient consent.

**Intervention**

Prior to the endoscopic procedure, the CT scans were carefully analysed. The CUSb-NA was performed under mild intravenous sedation (fentanyl 0.05–0.1 mg, midazolam 1–5 mg), using the BF-UC160F-OL8 and BF-UC180F ultrasound videobronchoscopes (Olympus Medical Systems Corporation, Tokyo, Japan). The ultrasound videobronchoscopes are 6.9 and 6.3 mm wide, have 2 and 2.2 mm working channels, respectively, and an oblique 35° optical system. The 7.5 MHz EU-C60 and 5–12 MHz EU-ME1 ultrasound processors were used, enabling 20–50 mm depth tissue imaging. As the ultrasound videobronchoscope is not designed for detailed assessment of the bronchial tree, the examination was preceded by the standard videobronchoscopy. For the biopsy, a cytological 22G needle with guidewire and marking facilitating its visualization on the ultrasound image was used (NA-201SX-4022, Olympus Medical Systems Corporation, Tokyo, Japan). CUSb-NA of detectable lymph nodes ≥5 mm on the short axis were performed (criterion of feasibility of lymph node biopsy according to Herth et al. [1] and Annema et al. [3]; first of all, enlarged nodes or those considered being suspicious based on the shape or echo-genicity were biopsied. All pretherapy positive stations were punctured by CUSb-NA, if only appeared. If there were no bigger nodes visible, even those >3 mm were punctured. All biopsies were performed through the macroscopically normal bronchial wall. The range of bioptised nodal stations in 1 patient was 1–5.

The cytological smear and cell blocks were performed and fixed using 96% ethanol. The specimens were sent to the cytological laboratory and the standard haematoxylin-eosin staining was used. The immuno and molecular staining was performed additionally if N2 disease was recognized by CUSb-NA.

In patients with negative or suspected for metastases (uncertain) results of the CUSb-NA, transcervical extended mediastinal lymphadenectomy (TEMLA) was performed. TEMLA includes bilateral dissection of all mediastinal lymph nodes, except for Station 9. The use of a special retractor, elevating the sternum, enables access to the mediastinal structures and safe dissection of lymph nodes. The technique of the TEMLA has been implemented since 2005 and presented in some publications [9, 18, 19].

In patients with negative results of the TEMLA who are fit enough for surgery, an appropriate pulmonary resection with dissection of the mediastinum was performed. The extent of the mediastinal dissection corresponded to the systematic lymph node dissection. Minimal N2 in our study refers to single lymph nodes found only in one mediastinal station regardless of whether lymphadenectomy was performed either by TEMLA or by thoracotomy. The Mountain-Dresler lymph node classification and [20] the seventh edition of tumour nodes metastases (TNM) classification were used.

**Statistical analysis**

The sensitivity, specificity, accuracy, PPV and NPV (including 95% confidence interval [CI]) were calculated using the GraphPad Instat 3.05 software (GraphPad Software, San Diego, CA, USA) and were based on the standard definitions. The bootstrap method was used (in Statistica™ Statsoft, Inc., USA environment) to compare the diagnostic values of different medical tests. Asymptotic normality of maximum likelihood estimates of the parameters of multinomial distribution and delta method were used to derive the asymptotic distribution of test statistics. The bootstrap approximations of this
test statistics were obtained from 2000 bootstrap replications. The significance level was set at $P \leq 0.05$.

**RESULTS**

From January 2009 to December 2012, 106 patients met the inclusion criteria and underwent restaging CUSb-NA. Fifteen patients were excluded from the trial—in 12 patients there was no response after induction therapy and in the remaining three there was lack of consent.

There were 78 men and 28 women in the mean age 61.5 ± (standard deviation) 8.1 years (range 45–83), respectively. In total, 286 mediastinal lymph node stations were biopsied: 1 (upper mediastinal)—3, 2R (right upper paratracheal)—12, 2L (left upper paratracheal)—12, 4R (right lower paratracheal)—52, 4L (left lower paratracheal)—97, 7 (subcarinal)—102, 8 (paraoesophageal)—6 and 9 (pulmonary ligament)—2. The number of nodes biopsied by CUSb-NA was 286 (mean 2.7, range 2–5) including 127 EBUS-TBNA (mean 1.2, range 1–3) and 159 EUS-FNA (mean 1.5, range 1–4).

The CUSb-NA established a diagnosis in 37/106 patients (34.9% true positive results): by EBUS-TBNA alone in 7 patients (6.6%), by EUS-FNA alone in 12 patients (11.3%) and by both methods in 18 patients (17.0%) (Figs 1 and 2).

In 69 (65.1%) patients with negative CUSb-NA, with 4 (3.8%) out of them with uncertain CUSb-NA, who underwent subsequent TEMLA, metastatic nodes were found in 18 patients (17.0%) and there was minimal N2 in 10 (9.4%). Among these 18 false-negative patients, there were 30 (10.5%) false-negative biopsies in stations: 2R—5, 2L—2, 4R—10, 4L—1, 5—4, 7—7 and 8—1. In 8 (7.6%) of these patients more than one station was involved: in 5 patients—2 stations (2R and 4R exclusively) and in 3 patients—multilevel stations. In 9 (8.5%) patients CUSb-NA occurred to be false negative in stations 2R and 4R (only accessible for EBUS), exclusively in small nodes (Fig. 3). In the remaining 4 (3.8%) patients, false-negative results were obtained in Station 5, not accessible for CUSb-NA. False-positive results were found in 2 (1.9%) patients out of the group with uncertain result of CUSb-NA.

The mean diameter of the biopsied nodes was 12.8 ± 7.6 mm in the long axis and 8.7 ± 5.8 mm in the short axis. The CUSb-NA was technically successful in 247 cases (86.5%), and in 92 of 286 biopsies (32.0%) the persistent nodal metastases were detected.

In 49 patients (46.2%), the result of CUSb-NA was true negative (Fig. 4). In this group, the cytological diagnosis of benign, reactive lymph node was subsequently confirmed by the histological examination of the TEMLA operative specimen, and in 37 patients (34.9%) with negative results of the TEMLA, additionally mediastinal dissection during thoracotomy was performed and no positive N2-3 nodes were found. The remaining 12 (11.3%) patients after TEMLA did not undergo lung resection. Eight (7.5%) patients out of them had a significant impairment of pulmonary function tests that made lung resection impossible, including 3 (2.8%) patients with temporary left nerve palsy, 4 (3.8%) patients with postoperative pulmonary insufficiency, suspected of having pulmonary embolism in whom 1 (0.9%) patient had pneumothorax, necessitating a chest drainage, and 1 (0.9%) had pleural effusion. One (0.9%) patient had a myocardial infarction and 3 (2.8%) patients refused the second surgery.

In 7 (6.6%) patients after TEMLA, asymptomatic widening of the mediastinum on chest X-ray was seen.

The prevalence of mediastinal lymph node metastases in the present study was 51.9%.
CUSb-NA and EBUS-TBNA are comparable.

The use of CUSb-NA performed simultaneously under mild sedation has never been presented as a standard method in minimal-invasive endoscopic NSCLC restaging. The sensitivity of large studies aimed to assess the diagnostic yield of CUS in NSCLC staging was 91.1–93%, the NPV was 91–97% and the accuracy was 91–97% [6, 7]. In one study analysing patients with small lymph nodes only, sensitivity was 68%, NPV was 91% and accuracy was 91%. The sensitivity of CUS was significantly better than that of EBUS (P = 0.04) and better than that of EUS (P = 0.07). Also, the NPV of CUS was significantly better than that of EBUS (P = 0.01) and EUS (P = 0.03) [8]. These results compare favourably with all other commonly used techniques of mediastinal staging of lung cancer. Although widely accepted in NSCLC staging, little is known about the role of EBUS and EUS in lung cancer restaging after induction therapy. So far, there were only few publications presenting 61 and 124 NSCLC patients for EBUS restaging and 58, 28 and 19 patients for EUS restaging [21–25]. In those papers, the sensitivity of EBUS-TBNA was 67% and 76% and of EUS was 44, 83 and 75%, whereas the NPV of EBUS-TBNA was 20% and 78% and of EUS was 58, 91.6 and 67%, respectively. All authors suggested that EBUS-TBNA and EUS-FNA are effective, less than for initial staging and also safe for mediastinal restaging, but negative results of them should be confirmed by surgical staging before thoracotomy.

The overall sensitivity of the CUSb-NA in NSCLC restaging calculated on a per patient basis was 67.3% (95% CI – 53–79), specificity 96.0% (95% CI – 86–99), total accuracy 81.0% (95% CI – 73–87), PPV 95.0% (95% CI – 83–99) and NPV 73.0% (95% CI – 61–83).

The diagnostic yield of EBUS-TBNA, EUS-FNA and CUSb-NA calculated on a per patient basis are presented in Table 1.

The sensitivity of CUSb-NA was significantly higher compared with EBUS-TBNA (P < 0.001) and EUS-FNA alone (P = 0.02). The total accuracy of CUSb-NA was also significantly higher compared with EBUS-TBNA alone (P = 0.006) and comparable with EUS-FNA alone (P = 0.99). The NPV of CUSb-NA was higher but not statistically significant compared with EBUS-TBNA (P = 0.30) and EUS-FNA alone (P = 0.28) (Table 2).

The durations of CUSb-NA, EBUS-TBNA, EUS-FNA and TEMLA were 15.2 ± 7.4 min (range 12–25), 12.1 ± 3.3 min (range 8–17), 5.1 ± 3.7 min (range 3–9) and 82.3 ± 24.4 min (range 55–106), respectively.

Neither complications nor morbidity and mortality were observed after CUSb-NA.

The cost of CUSb-NA procedure is slightly higher than that of separate EBUS-TBNA. The total consumption of biopctic needles during CUSb-NA is 15% higher than during EBUS-TBNA. The repair and depreciation cost of endoscopic equipment is also minimally higher (8%). The costs, medical materials and medicines for CUSb-NA and EBUS-TBNA are comparable.

**DISCUSSION**

The use of CUSb-NA performed simultaneously under mild sedation has never been presented as a standard method in minimally invasive endoscopic NSCLC restaging. The sensitivity of large studies aimed to assess the diagnostic yield of CUS in NSCLC staging was 91.1–93%, the NPV was 91–97% and the accuracy was 91–97% [6, 7]. In one study analysing patients with small lymph nodes only, sensitivity was 68%, NPV was 91% and accuracy was 91%. The sensitivity of CUS was significantly better than that of EBUS (P = 0.04) and better than that of EUS (P = 0.07). Also, the NPV of CUS was significantly better than that of EBUS (P = 0.01) and EUS (P = 0.03) [8]. These results compare favourably with all other commonly used techniques of mediastinal staging of lung cancer. Although widely accepted in NSCLC staging, little is known about the role of EBUS and EUS in lung cancer restaging after induction therapy. So far, there were only few publications presenting 61 and 124 NSCLC patients for EBUS restaging and 58, 28 and 19 patients for EUS restaging [21–25]. In those papers, the sensitivity of EBUS-TBNA was 67% and 76% and of EUS was 44, 83 and 75%, whereas the NPV of EBUS-TBNA was 20% and 78% and of EUS was 58, 91.6 and 67%, respectively. All authors suggested that EBUS-TBNA and EUS-FNA are effective, less than for initial staging and also safe for mediastinal restaging, but negative results of them should be confirmed by surgical staging before thoracotomy.

In our study, the mean numbers of biopsied lymph node stations by use of EBUS-TBNA, EUS-FNA and CUSb-FNA were 1.2, 1.5 and 2.7, respectively in comparison with the mean number of 27.4 nodes removed during restaging TEMLA. Such a big difference in the number of examined nodes may be the main reason for the difference in the diagnostic yields among minimally invasive biopctic methods and TEMLA.

A major advantage of CUSb over TEMLA is that no morbidity and mortality was observed after CUSb-NA and the overall morbidity of restaging TEMLA was 7.5%.

Gaining skills and experience in the endobronchial and endoscopic ultrasound imaging and performing the biopsy in restaging is more time-consuming and operator-dependent than in standard staging performed by EBUS, EUS and CUSb. It is very difficult, even for experienced endoscopist, to distinguish between suspected region for metastases and postinflammatory adhesions, degenerative changes and fibrosis after oncological treatment. This may also be the reason of the technical failure in >13% of biopsies.

In our study, a diagnostic yield of CUSb-NA in restaging of NSCLC patients with 51.9% prevalence of metastatic nodes was quite high: sensitivity – 67.3%, total accuracy – 81.0% and NPV – 73.0%. The NPV of CUS performed by use of two different scopes

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**Table 1:** Diagnostic utility of biopctic techniques calculated on a per patient basis in NSCLC restaging after induction therapy

<table>
<thead>
<tr>
<th>Biopctic technique</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Total accuracy (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBUS-TBNA</td>
<td>48 (34–62)</td>
<td>98 (90–100)</td>
<td>74 (64–81)</td>
<td>96 (80–100)</td>
<td>66 (55–76)</td>
</tr>
<tr>
<td>EUS-FNA</td>
<td>61 (46–75)</td>
<td>98 (91–100)</td>
<td>81 (72–87)</td>
<td>97 (83–100)</td>
<td>71 (58–84)</td>
</tr>
<tr>
<td>CUSb-NA (in all mediastinal stations)</td>
<td>67 (53–79)</td>
<td>96 (86–99)</td>
<td>81 (73–87)</td>
<td>95 (83–99)</td>
<td>73 (61–83)</td>
</tr>
<tr>
<td>CUSb-NA (in stations accessible for CUS)</td>
<td>70 (56–82)</td>
<td>96 (87–99)</td>
<td>83 (75–89)</td>
<td>95 (83–99)</td>
<td>76 (64–86)</td>
</tr>
</tbody>
</table>

**Table 2:** A comparison of diagnostic yield of CUSb with that of EBUS and EUS alone

<table>
<thead>
<tr>
<th>Diagnostic yield per patient</th>
<th>CUSb/EBUS, P-value</th>
<th>CUSb/EUS, P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>&lt;0.001</td>
<td>0.02</td>
</tr>
<tr>
<td>Specificity</td>
<td>0.30</td>
<td>0.28</td>
</tr>
<tr>
<td>Total accuracy</td>
<td>0.006</td>
<td>0.99</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>0.70</td>
<td>0.48</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>0.30</td>
<td>0.28</td>
</tr>
</tbody>
</table>

The over all sensitivity of the CUSb-NA in NSCLC restaging calculated on a per patient basis was 67.3% (95% CI – 53–79), specificity 96.0% (95% CI – 86–99), total accuracy 81.0% (95% CI – 73–87), PPV 95.0% (95% CI – 83–99) and NPV 73.0% (95% CI – 61–83).

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The sensitivity of CUSb-NA was significantly higher compared with EBUS-TBNA (P < 0.001) and EUS-FNA alone (P = 0.02). The total accuracy of CUSb-NA was also significantly higher compared with EBUS-TBNA alone (P = 0.006) and comparable with EUS-FNA alone (P = 0.99). The NPV of CUSb-NA was higher but not statistically significant compared with EBUS-TBNA (P = 0.30) and EUS-FNA alone (P = 0.28) (Table 2).

The durations of CUSb-NA, EBUS-TBNA, EUS-FNA and TEMLA were 15.2 ± 7.4 min (range 12–25), 12.1 ± 3.3 min (range 8–17), 5.1 ± 3.7 min (range 3–9) and 82.3 ± 24.4 min (range 55–106), respectively.

Neither complications nor morbidity and mortality were observed after CUSb-NA.

The cost of CUSb-NA procedure is slightly higher than that of separate EBUS-TBNA. The total consumption of biopctic needles during CUSb-NA is 15% higher than during EBUS-TBNA. The repair and depreciation cost of endoscopic equipment is also minimally higher (8%). The costs, medical materials and medicines for CUSb-NA and EBUS-TBNA are comparable.
was higher 82.1% [9]. A similar tendency was observed in the study comparing two methods CUS vs CUSb in primary NSCLC staging (90.7 vs 82.0%) [13].

But most importantly, the sensitivity of CUSb-NA was significantly higher compared with EBUS-TBNA (P < 0.001) and EUS-FNA alone (P = 0.02), and likewise the total accuracy of CUSb-NA was also significantly higher compared with EBUS-TBNA alone (P = 0.006). The NPV of CUSb-NA was higher compared with EBUS-TBNA (P = 0.30) and EUS-FNA alone (P = 0.28). It confirms the superiority of the combined approach compared with EBUS and EUS alone in detecting metastases. Moreover, the mean time of restaging CUSb-NA was 15.2 ± 7.4 min (range 12–25) and comparable with the mean time of staging CUSb-NA [13].

In our study, there was no straight comparison of an economical evaluation between CUS and CUSb. However, it seems that the CUSb has the advantage of being more economical than CUS, because of the use of only one ultrasound bronchoscope in one session but it requires further trials.

The cost of CUSb-NA is slightly higher than that of single EBUS-TBNA mainly because of the 15% higher use of biopptic needles and 8% higher cost of the repair and depreciation of endoscopic equipment.

The major limitation of our study was lack of routine use of positron emission tomography combined with computed tomography, which might increase the accuracy of the restaging CUSb-NA while indicating stations for precise puncturing. There are also several factors that might influence the reliability of the restaging CUSb-NA such as: primary invasive staging only performed by use of biopptic techniques or the number of chemotherapy cycles (3–5 in our study) and a different interval time between the date of the end of induction therapy and CUSb-NA. However, due to high efficiency and low invasiveness, a combined endoscopic technique by use of a single bronchoscope may become the method of choice in invasive NSCLC restaging.

CONCLUSIONS

(i) CUSb-NA is an accurate, reasonable and safe technique in mediastinal restaging in NSCLC patients after induction therapy.

(ii) Following our data, in patients with negative result of CUSb-NA, a further surgical restaging of the mediastinum should be thoroughly considered.

Conflict of interest: None declared.

REFERENCES


