Cesario A, cell lung cancers (NSCLCs) remains up for discussion in the scientific community, especially regarding the surgical approach. In this setting, we have read with great interest the recent article by Toufektzian and co-workers [1], who have reviewed the pertinent literature with the aim of clarifying whether the extent of pulmonary resection substantially affects survival in patients with synchronous multiple primary lung cancers. As already suggested by ourselves [2], the International Association for the Study of Lung Cancer (IASLC) has recently issued a revised adenocarcinoma classification [3], reclassifying the entire category of pulmonary adenocarcinomas into three categories (adenocarcinoma in situ [AIS], minimally invasive adenocarcinoma [MIA] and invasive adenocarcinomas [IA]) with several surgical implications. Indeed, as remarked in detail by Van Schil et al. [4], the “early-stages” AIS and MIA should have a disease-specific survival of 100% or near 100% after sublobar resection and mediastinal sampling, respectively. To simplify, we may assume that this new classification should be take in mind when planning the best surgical strategy in second primary NSCLCs. Therefore, the decision of performing a sublobar resection instead of standard anatomical resection in patients with adenocarcinoma should be based (in the forthcoming future) not only on clinical considerations (parenchymal-sparing strategy when a bilateral resection is previewed) but also on histological features (and the oncological implications related to them). Unfortunately, detailed preoperative histological features are not always achievable in daily clinical practice, a fact that substantially limits the clinical impact of such considerations. In conclusion, the histological features of synchronous multiple primary lung cancers represent relevant information when planning the best surgical management. The authors’ reflections and reactions on the points raised would be greatly appreciated.

Conflict of interest: none declared.

References


The best therapeutic strategy for synchronous/metachronous primary non-small cell lung cancers (NSCLCs) remains up for discussion in the scientific community, especially regarding the surgical approach. In this setting, we have read with great interest the recent article by Toufektzian and co-workers [1], who have reviewed the pertinent literature with the aim of clarifying whether the extent of pulmonary resection substantially affects survival in patients with synchronous multiple primary lung cancers undergoing curative surgery. In the clinical scenario, the patient was affected by a synchronous lung cancer with only one (upper or lower lesion) pathologically proven as squamous cell carcinoma. Although we concur with the conclusion of Toufektzian and colleagues, who recommend bilateral anatomical lung resections (pneumonectomy excluded) only in those cases where there are no concerns about postoperative pulmonary reserve, we wish to better define (and distinguish) such a challenging strategy of care according to the histology of synchronous multiple primary lung cancers. As already suggested by ourselves [2], the International Association for the Study of Lung Cancer (IASLC) has recently issued a revised adenocarcinoma classification [3], reclassifying the entire category of pulmonary adenocarcinomas into three categories (adenocarcinoma in situ [AIS], minimally invasive adenocarcinoma [MIA] and invasive adenocarcinomas [IA]) with several surgical implications. Indeed, as remarked in detail by Van Schil et al. [4], the “early-stages” AIS and MIA should have a disease-specific survival of 100% or near 100% after sublobar resection and mediastinal sampling, respectively. To simplify, we may assume that this new classification should be taken in mind when planning the best surgical strategy in second primary NSCLCs. Therefore, the decision of performing a sublobar resection instead of standard anatomical resection in patients with adenocarcinoma should be based (in the forthcoming future) not only on clinical considerations (parenchymal-sparing strategy when a bilateral resection is previewed) but also on histological features (and the oncological implications related to them). Unfortunately, detailed preoperative histological features are not always achievable in daily clinical practice, a fact that substantially limits the clinical impact of such considerations. In conclusion, the histological features of synchronous multiple primary lung cancers represent relevant information when planning the best surgical management. The authors’ reflections and reactions on the points raised would be greatly appreciated.

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