Discussion to: En-bloc chest wall resection in locally advanced cT3N2 (stage IIIIB) lung cancer involving the chest wall: Revisiting guidelines

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Mr Joseph F. Zywiciel (Maywood, Ill). Correct.

Dr Thomas D’Amico (Durham, NC). Thank you, Joseph. Thanks for sending the manuscript a year-and-a-half ago. It was good to really get to absorb it. It was wonderful. You should retain that habit if you go into general surgery—to be a general thoracic surgeon, to be on time. Many of us aren’t. So, I think the biggest problem with the presentation of the paper is the conclusion that the National Comprehensive Cancer Network guidelines should be revisited. You probably didn’t take Latin, but the phrase res ipsa loquitur, “the thing speaks for itself.” The National Comprehensive Cancer Network guidelines are designed to look at 80 to 90% of patients. You have found a group that’s less than 1.9%. And so, the guidelines don’t have to be revisited, but the way we look at algorithms in the guidelines can be reconsidered based on these data, which is probably already happening in many places, is that patients with a minimal amount of N2 disease and chest wall resection are being considered for surgery. So based on that, I just have a couple of questions based on your population. Now, in the propensity match about selection bias, in the propensity-matched group, the 2-year survival was pretty close to zero, right?

Mr Zywiciel. Yeah. And I agree with what you’re saying. I know that we tried our best to kind of remove those kind of confounding variables through the propensities we’re mentioning. As you stated, obviously, that the group that we’re selecting is a very select group of patients. And even the database, I would say is kind of select as comparable to national representative data. And I think that there is inherent selection in there, but I think that that’s again, as you stated, key to when you’re going through surgical decision making and things like that where you’re not exclusively ruling out the need for surgery and things like that.

Dr D’Amico. And in other papers, such as Pacific, which didn’t have chest-wall involvement, were probably a little better category, but the 2-, 3-, 4-year survival is in the 20% range, 30% without surgery. So, it’s possible that in this small group in the National Cancer Database is not representative of everything we see all the time. And, second, the point that you brought up—so do you have any comments about that, about modern therapy and that this population, the outcome close to 0% might not be representative.

Mr Zywiciel. Yeah. And I agree with what you’re saying. I know that we tried our best to kind of remove those kind of confounding variables through the propensities we’re mentioning. As you stated, obviously, that the group that we’re selecting is a very select group of patients. And even the database, I would say is kind of select as comparable to national representative data. And I think that there is inherent selection in there, but I think that that’s again, as you stated, key to when you’re going through surgical decision making and things like that where you’re not exclusively ruling out the need for surgery and things like that.

Dr D’Amico. Yes. And I think the answer to the problem would be if we could do a clinical trial with these patients. But it’s difficult to do a clinical trial with such a small number. And my only other comment would be, and you brought it up, these are clinical N2 disease. So, if a surgeon in the United States decided to take a patient to the operating room with T3N2 disease, they probably had just a little bit of N2 disease. Whereas all of the patients that got radiation could have had massive N2 disease and could have had N3 disease for all we know. And then the other point about in modern therapy adding immunotherapy to the nonsurgical group is going to change that population. And the last question, you mentioned a 3.3% 30-day-mortality, and you mentioned that it was similar to a Society of Thoracic Surgeons study, but the
real operative mortality is almost 10%, right? The 90-day mortality, that’s really the operative mortality. I think we just have to be careful about recommending operations that have a nearly 10% operative mortality. Thank you very much. That was a wonderful presentation, and your paper is great.

Mr Zywiciel. Thank you.

Conflict of Interest Statement

The authors reported no conflicts of interest.

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