but only for well-selected patients (young, without history of malignancy or smoking, with a nodule radiologic pattern of benignity or nodules with small dimension). We think that the clinician in a well-determined situation does have the option of a short watchful period.⁴ But for us the watchful period doesn't last 90 days without any radiologic control; in fact our waiting period is shorter than 90 days, and every 20 days we perform a thoracic computed tomographic scan.

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References

1. Quarterman RL, McMillan A, Ratcliffe MB, Block MI. Effect of preoperative delay on prognosis for patients with early stage non-small cell lung cancer. *J Thorac Cardiovasc Surg.* 2003;125:108-14.
2. Tang AW, Moss HA, Robertson RJ. The solitary pulmonary nodule. *Eur J Radiol.* 2003;45:69-77.
3. Andrea S, Paolo C, Ascanelli S, Davide S, Enzo P. Significance of a single pulmonary nodule in patients with previous history of malignancy. *Eur J Cardiothorac Surg.* 2001;20:1101-5.
4. Ginsberg RJ. The solitary pulmonary nodule: can we afford to watch and wait? *J Thorac Cardiovasc Surg.* 2003;125:25-6.
doi:10.1016/S0022-5223(03)00578-6

Reply to the Editor:

My coauthors and I greatly appreciate Sortini and colleagues' comments, and we agree with their premise that prompt resection of suspicious solitary pulmonary nodules is the standard of care. However, this is a separate issue from the central conclusion of our report that there remains no good evidence to indicate that watchful waiting for selected patients worsens prognosis. This question is unlikely to be answered without a prospective trial, and we are therefore left with reasoned discussion of the evidence available.

Sortini and colleagues first take issue with our suggestion that tumor biology, and not just duration of tumor growth, may be an important factor in the observation that larger tumors are associated with a worse prognosis. Our intent was to point

out that the data on tumor size and prognosis provide only circumstantial evidence for the importance of time and cannot be interpreted as proof that watchful waiting is necessarily bad. Other factors are also at play, among which tumor biology, independent of time, must be a consideration. When confronted with a nodule of low suspicion, we are then left with the question of how important time is. This leads to their second concern, that our choice of 90 days as a cutoff was inappropriate. They suggest that comparison to a group of patients who had surgery within 10 to 15 days would be more meaningful. This window is as arbitrary as any other, and 90 days was chosen for the variety of practical reasons cited in our report. Unfortunately, we are often confronted with circumstances beyond our control (such as delays in referral to a specialist, comorbidities that require evaluation and management, resource limitations that delay scheduling of necessary preoperative testing, and patient preferences) that limit our ability to bring patients to surgery expeditiously. Furthermore, we attempted to start the clock ticking with the very first chest radiograph that showed a nodule, as opposed to the date of the chest computed tomographic scan or the visit to the specialist. Thus a 15-day cutoff would be bound to produce a cohort of patients that not only would be small relative to the entire group but might also be preselected for few comorbidities and good performance status, factors that are known to favorably affect prognosis. Interestingly, Sortini and colleagues conclude by agreeing that short-term watchful waiting is appropriate in selected circumstances. Thus the optimal duration of this period remains the only open question. They have chosen 20 days, an aggressive approach that seems of questionable value.¹ As mentioned in both our report and Dr Ginsberg's accompanying commentary,² new computed tomography algorithms that enable volumetric modeling may permit accurate assessments of doubling times during relatively short periods (although 20 days seems ambitious).¹ The potential for this technology is exciting, but it is not yet either mature or widely available, and its value has not been demonstrated.

We hope that one day we will be able to tell with a high degree of certainty whether any given lung nodule is benign or malignant,

and do so at reasonable cost with no morbidity. Until then, we must deal with the question of how much economic cost and potential morbidity are justified by the time benefit to those patients whose nodules are malignant. Unfortunately, we have so far been unable to quantify that benefit.

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References

1. Winer-Muram HT, Jennings SG, Tarver RD, Aisen AM, Tann M, Conces DJ, et al. Volumetric growth rate of stage I lung cancer prior to treatment: serial CT scanning. *Radiology.* 2002;223:798-805.
2. Ginsberg RJ. The solitary pulmonary nodule: can we afford to watch and wait? *J Thorac Cardiovasc Surg.* 2003;125:25-6.
doi:10.1016/S0022-5223(03)00579-8

Malignant status at surgical margin of limited-resected non-small cell lung cancer: A crucial finding for predicting local relapse

To the Editor:

In a recent issue, Higashiyama and colleagues¹ reported on the malignant status of the surgical margin of limited-resected non-small cell lung cancer (NSCLC). They concluded that the cytologically negative results of examination of the surgical margin by the technique of intraoperative lavage in limited surgery for lung cancer may be predict lack of local recurrence in the surgical margin. The results in Higashiyama and colleagues' study¹ are similar to those of my own investigation.² As such, I believe Higashiyama and colleagues' technique is also useful to find out whether NSCLC has been resected completely.

Although no recurrence on the malignant negative surgical margin was found in Higashiyama and colleagues' study,¹ I have a criticism of their technique in correcting cells on the surgical margin. It is not rare that malignant cells exist on the pleura in the naked situation³ and after needle aspiration cytologic examination.⁴ Their complicated technique was lavage cytologic examination without flooding the pleura. If the pleura is flooded for even a short while, malignant cells on the pleura contaminate it. However, it is difficult to avoid flooding the pleura with saline solution in a cup. Further, the spun cells degen-