Figure 1. Application of molecular biology to refine the assessment of risk and guide the use of adjuvant chemotherapy in stage IA non-small cell lung cancer (NSCLC).

or targeted therapeutic agents at time of recurrence. Therefore, development of a tissue and blood (serum, plasma, and circulating cells) bank with specimens obtained in clinical trials, including detailed prospective collected clinical data, is of the utmost importance. This new phase of target profiling and agent-specific profiling will probably require an algorithm that would include genomic, proteomic, clinical, and imaging factors.

Patients with early-stage NSCLC will be assigned to particular drugs on the basis of the molecular characteristics of their tumors. Then the development of drugs for the treatment of NSCLC will be focused on personalized therapy.

Figure 1 outlines a possible application of molecular biology to refine the assessment of risk and guide the use of adjuvant chemotherapy in stage IA NSCLC.

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Focus on the Thoracoscore

To the Editor:

It is with great interest that we read the article entitled "Thoracoscore predicts midterm mortality in patients undergoing thoracic surgery."¹ The authors' findings and conclusions concur perfectly with those of our initial main work, which first created and proposed the use of the Thoracoscore.² However, we would like to emphasize 2 points that we consider to be important.

First, one of our concerns is the reliability of any modification in the French scoring system (Thoracoscore), as was done with the dyspnea score in the present study. This point is particularly crucial. Effectively, our initial aim was to develop a self-assessment system based on a large database reflecting current practices in adult thoracic surgery. Nine predictors were selected from the database. Their definitions, which are consistent throughout the world and particularly in North American systems, were objective enough to develop

a reliable scoring system that could be used by all thoracic surgeons and for all types of thoracic procedures. This is why we think that the Thoracoscore can be used as a relevant yardstick for mortality. Moreover, the French scoring system, built on well-defined risk factors, is also user friendly and imposes minimal demands on medical time. At this point, a word of caution is essential: the condition under which such a system is used needs to be considered. The Thoracoscore was constructed so as to deal with the problem of a missing item. Indeed, in the case of 1 or more items missing from the 9 predictors selected, the Thoracoscore gives a range (minimum and maximum values) of estimated mortality rather than a percentage of predictive mortality. Thus it can be used easily, as is.

Second, why is the Thoracoscore a reliable tool, and how can it be used worldwide? The Thoracoscore is reliable because it comes from a national electronic prospective database created by a national society of thoracic and cardiovascular surgery. Indeed, the French database Epithor, created in 2002 on behalf of the French Society of Thoracic and Cardiovascular Surgery, includes anonymous information from two thirds of all thoracic surgery procedures performed in France each year (>60,000 from 59 centers: 37 public and 15 private). Each center is free to compare its statistics and results with the national means. It can also be used to register patients for administrative hospital files. In addition, Epithor is now mandatory for the accreditation of thoracic surgery departments. Therefore the Thoracoscore tool can be transposed to any organization (country/

department) with an exhaustive database controlled by a scientific committee.

Furthermore, thoracic surgical education has become a priority within the French Society of Thoracic and Cardiovascular Surgery, thanks to the French College of Thoracic and Cardiovascular Surgery (eg, a prerequisite for diplomas, board certification, continuing medical education, and postgraduate course), and the French program for quality of care assessment for surgical procedures, to which Epithor belongs, in adult thoracic surgery is a now a reality (ad hoc committees for audit and clinical relevance and for database).

Finally, we are certain that much is to be gained from external validations, such as the one done at St Luke's–Roosevelt Hospital Center of Columbia University. To reach an international consensus through such validations would greatly enhance the strength of the Thoracoscore.

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