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Reply to the Editor:

We appreciate the interest expressed by Kubisa, Grodzki, and Wójcik in our recently published study concerning silver nitrate technique for the management of small bronchopleural fistulas.¹ We are glad to learn that other colleagues as well have experience with this method.

As we noted twice in our study, although this technique was described once, 25 years ago,² nothing has been reported since on the subject, and it is certain that younger generations of pulmonologists and thoracic surgeons alike are not acquainted with it. In an extensive review on the endoscopic management of bronchopleural fistulas published recently as well, nothing more than the above was reported.³

The references mentioned by Kubisa, Grodzki, and Wójcik were all published during the 1950s and 1960s, *before the advent of the flexible bronchoscope*, and referred mainly to complications of *endobronchial tuberculosis*, which is a completely different situation (and topic), ideally rare nowadays.

To our knowledge, based on a systematic research of the literature, our report is the first in the modern era to present this safe and effective technique for endoscopic management of such a serious and difficult-to-treat complication.

With regard to complications and safety, we have already described possible casualties in our report,¹ and we are currently working on developing a new bronchoscopic silver nitrate applicator for safer and simpler use with modern flexible bronchoscopes.

We totally agree that much work has to be done in the domains of pre-

vention and new techniques. However, we also believe that revisiting old ideas and techniques (if they are forgotten and continue to be valid) is important and can be of considerable help for clinicians in their daily practice.

G. Stratakos, MD^a

Ch. Zisis, MD, FETCS^b

St. Gasparini, MD^c

^aCritical Care and Respiratory Division

University of Athens, Greece

^bThoracic Surgery Department

“Evangelismos” Hospital

Athens, Greece

^cPulmonary Diseases Unit

Department of Internal Medicine

Immunoallergic and Respiratory

Diseases

“Ospedali Riuniti”

Ancona, Italy

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PNEUMONECTOMY AFTER INDUCTION RADIOCHEMOTHERAPY: IS IT TIME FOR A META-ANALYSIS?

To the Editor:

The discussion regarding the safety and feasibility of pneumonectomy for non-small cell lung cancer after induction chemoradiotherapy (IT) is a long-standing, widely debated issue, in particular, in the past 2 decades.

We read with great interest the review from Krasna,¹ in which pneumonectomy after IT is finally judged as a risky procedure (especially if right-sided) that, until further validation (via prospectively gathered data),

should be “used with caution in experienced centers.”

We wish to express our viewpoint and ask the authors about their opinion on the basis of our own long-term experience with IT,² our recently reported results on pneumonectomy after IT,³ and in the light of other recently published authoritative reports.^{4,5} In particular, we have evaluated the outcome-related data of 85 (49 after IT) consecutive standard pneumonectomies in a 14-year period. Operative mortality and morbidity do not seem to be directly associated with IT; besides, among the clinical, surgical, and pathologic features, the right-sided pneumonectomy showed a worse long-term survival in the overall population regardless of the prior application of IT. Substantially, the same old questions still stay unanswered: Is pneumonectomy a feasible and safe procedure after IT? Are there criteria to stratify the correlated risk after IT-pneumonectomy? Do long-term oncologic results justify this treatment?

On top of this, it is impossible not to consider that a complete resection (thus including the pneumonectomy option) must be attempted if a radical chance of cure is sought and the conditions for resectability are met or re-met after IT.

Still, the indication for pneumonectomy after IT is not yet strictly evidence-based, and a prospective approach is difficult to imagine given the substantial impossibility to design a trial with a proper control group: radical resection in NSCLC, in fact, has no ethical comparator alternative. As well, when the concept of “experienced center” is analyzed, the criteria to define it are in doubt? If present, are these criteria validated? What is the referral benchmark of this validation: survival or mortality/morbidity? What is the correct (ethical) approach to the information given to the patient when a pneumonectomy is offered after an IT?

In our opinion, in reality, the “experienced centers” are those in which the