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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.

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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

team approaching these cases “dares” to put it in place.

Krasna¹ comments that data “are to be taken with a grain of salt.” In our opinion, it is time for the surgical and oncologic scientific societies to open the discussion to pave the way for a meta-analysis on this topic. We do believe, in fact, that recommending a pneumonectomy after IT is an extremely delicate issue and that this decision should be supported by the most reasonable achievable base of evidence.

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Reply to the Editor:

I thank Cusumano, Cesario, and Margaritora, of the Division of Thoracic Surgery, Catholic University, Rome, Italy, for their letter. I absolutely agree with them that there are cases in which pneumonectomy should be performed after induction chemoradiation therapy. It was the intent of my “counterpoint” article to identify through a review of recent articles whether there was enough evidence to state that the use of pneumonectomy in this setting was standard or not. Thus far, the number of articles supporting this approach remain outweighed by those against its use. Recently, however, several articles have appeared in the thoracic journals that *do* provide new data supporting the use of pneumonectomy in this setting.¹⁻⁴ Given these recent articles, as well as the practice of several centers in the United States and in Europe, I would agree that a meta-analysis should be undertaken. This may be difficult inasmuch as many of the articles use different end points and definitions. Rather, a combined report from several sites sharing specific variables would be a helpful first step. I for one would look forward to joining with this effort.

At the present time, despite my strong *feelings* that pneumonectomy should be done, further definition of the correct subgroup and standardization of the approach are still begging.

I applaud the group from Rome as well as their colleagues at the other two large Roman hospitals who have pursued this approach aggressively and look forward to collaborating with them.

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