randomized trials in high-risk patients are needed.

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NO MATTER HOW COMPLEX THE PROBLEM, THERE IS ALWAYS A SIMPLE SOLUTION—WHICH IS WRONG!

To the Editor:

Is it the cough that carries them off?

Asbestos-related pulmonary disease, and specifically the development of mesothelioma, continues to be a tragic health issue. There are characteristics of the whole disease entity that seem both unusual but interrelated. The inhalation of relatively long asbestos fibers is followed by their transport to the visceral pleura and subsequently to the parietal pleura and, via lymphatics, elsewhere. The fibers produce subpleural fibrosis in the lungs, but this discussion relates to the more

significant parietal pleural changes. Usually, the first and most diagnostic appearance is that of pleural plaques, with or without calcification, at chest radiograph or computed tomographic scan. There are several features of these that warrant consideration.

1. They involve the parietal pleura and not the visceral.
2. They arise in areas of greatest movement between the opposing pleural layers, with respiration, coughing, and sneezing. They do not occur over the lung apices or within the interlobar fissures where the pleural surfaces move in unison.
3. The plaques and calcifications tend to group deep to the ribs. And yes, some also form over the diaphragm and pericardium.

A simple question then arises—Is the development of pleural plaques and subsequent mesothelioma a result of chronic abrasive trauma caused by these fibers at the visceral surface abraiding the parietal pleura, akin to oral tumors resulting from “ill fitting dentures?” This would then infer a mechanical etiology rather than a chemical carcinogenesis and perhaps explain why other fibers with similar physical characteristics have also been implicated or are under suspicion. Of interest, talc had been viewed with suspicion by some because of its fiber structure, but the fact that it produces pleurodesis would negate any such effect.

If this hypothesis is worthy of consideration, several other points arise.

The negative pressure within the pleural cavity during quiet respiration, maintaining the apposition of the visceral and parietal pleural layers, is very low, and this would by inference reduce abrasive effects. However, during coughing the glottis closes while the intercostal muscles and abdominal wall muscles contract, increasing the intrathoracic and intrapleural pressure before there is an explosive release of air from the chest. The markedly increased direct pressure exerted by the ribs on the underlying pleural space may explain the

apparent predilection of pleural plaques for these regions.

If these suppositions hold weight, then an obvious question arises. Is there a place for prophylactic pleurodesis in the prevention of mesothelioma by preventing chronic abrasion between the pleural surfaces?

The risk of development of mesothelioma in those with asbestos-related disease has been quoted at 10%, a figure presumably subject to much discussion. It may be arguable whether even a procedure of low morbidity should be universally proposed as a panacea. However, other factors, possibly including plaque load, life expectancy, smoking, and chronic cough, may enable identification of higher risk groups for whom active intervention may be justified.

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ALICE IN WONDERLAND OF MEDIASTINAL LYMPH NODES To the Editor:

We read with great interest the results of the American College of Surgery Oncology Group (ACOSOG) Z0030 trial,¹ which was a randomized, multi-institutional, prospective trial of mediastinal lymph node dissection (MLND) versus sampling (MLNS) during pulmonary resection for patients with early-stage (N0 or nonhilar N1, T1, or T2) non-small cell lung cancer (NSCLC). At a median follow-up of 6.5 years, 44% died in the MLNS arm and 42% died in the MLND arm, and the median survival was 8.1 years in the MLNS group and 8.5 years in the MLND group ($P = .25$). Studies addressing the survival benefit of MLND, however, have been inconclusive. We herein performed a meta-analysis of randomized controlled trials of MLND versus MLNS during pulmonary resection for prevention of all-cause mortality in early-stage NSCLC.