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THE SURGICAL MANAGEMENT OF LUNG CANCER IN THE UNITED KINGDOM BETWEEN 2004 AND 2009

To the Editor:

We would like to comment on surgical management of the lung in the United Kingdom for the period from 2004 to 2009. Surgical management offers can be curative but there are little data on the subsequent prognosis of patients in the United Kingdom. Pneumonectomy and lobectomy have reported mortality rates of 6% to 8% and 2% to 4%, respectively.¹⁻⁴ Our study aimed to assess diagnostic methods, staging, and long-term prognosis in surgically managed patients with lung cancer. We retrospectively analyzed the medical notes of all surgically managed lung cancer patients in a National Health Service hospital between 2004 and 2009. Only 40 patients were identified, 80% had non-small-cell lung cancer and in the remaining patients no tissue diagnosis was made. Ninety percent were staged node negative via a combination of both positron emission tomography and computerized tomography scanning. No patients received preoperative down-staging adjuvants.

Mortality rates at both 6 months and 1 year was 25%. There were no surgical deaths or deaths in the immediate

postoperative period. All patients who died within 6 months of surgery had radiologic evidence of metastatic disease and lung cancer specified on their medical cause of death certificate.

Thirty percent of patients received postoperative chemotherapy, 3% of patients received postoperative radiotherapy, and 6% of patients received both chemotherapy and radiotherapy. In the patients who died, the median survival time was 5.3 months. Three of the 10 patients who died had evidence of metastatic thoracic disease at surgery. Tumor staging was comparable between those who died and those who were cured.

In conclusion, surgical management was curative (defined as no evidence of metastatic disease at 1 year postoperatively) in 30 patients (75%). In those patients who were not cured, prognosis was poor and comparable with those who did not have surgery. Tumor staging did not affect outcome.

Our study was largely historical and showed practice before the update to the guidelines in 2011⁵ such that now patients undergoing surgery with curative intent should first have hilar and mediastinal lymph node sampling, or otherwise undergo bloc resection. Second, many of our patients proceeded to surgery without histologic evidence of disease. Obtaining histologic proof can be difficult; tumors on the periphery of the lung cannot be visualized with conventional bronchoscopy but the new guidelines have evolved to include endobronchial ultrasound (EBUS), which may reduce the number of thoracotomies occurring without prior

histologic diagnosis. The limitations to our study stem from our limited number of cases, poorly maintained registry, and its historical nature. However, we hope this letter encourages others to perform a larger study that examines the effects of EBUS and preoperative staging on results. This is very important because the costs involved in creating an EBUS service are significant and must be justified in the context we have outlined.

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Notice of Correction

Re: Tzao C, Hsu H-S, Sun G-H, Lai H-L, Wang Y-C, Tung H-J, et al. Promoter methylation of the *hMLH1* gene and protein expression of human mutL homolog 1 and human mutS homolog 2 in resected esophageal squamous cell carcinoma. *J Thorac Cardiovasc Surg*. 2005;130:1371-7.

In the above-mentioned article, the spelling of Ms. Lai's given name was incorrect. The corrected author list is printed below.

Ching Tzao, MD, PhD, Han-Sui Hsu, MD, Guang-Huan Sun, MD, PhD, Hsiao-Lei Lai, BS, Yi-Ching Wang, PhD, Ho-Jui Tung, PhD, Cheng-Ping Yu, MD, PhD, Yeung-Leung Cheng, MD, PhD, and Shih-Chun Lee, MD