score in the PARTNER Trial.”¹ They pointed to the limited utility of the EuroSCORE I² and newer EuroSCORE II³ algorithms to predict the outcomes of patients undergoing cardiac surgery and attributed this limited utility to heterogeneous patients, evolving surgical techniques and postoperative care, and outcome variability among surgeons and institutions.⁴ Although our report pointed to the limitations of the current algorithms when applied to a transcatheter aortic valve replacement (TAVR) population, we did not specifically address how to create new TAVR-specific algorithms. We agree with Dr Hernandez-Vaquero that developing TAVR-specific scores would be a most challenging but important task and that useful TAVR-specific scores will require a large cohort of patients from different centers and must include the most clinically relevant variables associated with TAVR outcomes. TAVR-specific risk scores are being developed, and we look forward to seeing their performance, especially as TAVR moves increasingly from randomized trials to real world applications.

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USE OF STEREOTACTIC BODY RADIATION THERAPY WITH SALVAGE SURGERY TO IMPROVE OUTCOMES FOR EARLY STAGE NON-SMALL CELL LUNG CANCER

To the Editor:

The role of stereotactic body radiation therapy (SBRT) and its integration into the treatment of early stage non-small cell lung cancer continues to evolve. The recent propensity-matched analysis by Crabtree and colleagues¹ provides insights into how to combine SBRT with surgery to improve non-small cell lung cancer outcomes.

Crabtree and colleagues¹ found that regional and distant recurrences were no different after SBRT or surgery throughout follow-up and that local recurrence alone caused the inferior disease-free survival seen with SBRT. This suggests that a strategy of using SBRT with prompt surgical salvage for suspected local recurrence may present the same probability of cure as surgery alone. With only 11% of patients having local recurrence after SBRT, the vast majority of SBRT-treated patients would not only achieve cure but also do so with lung preservation. SBRT with surgical salvage would immediately reduce operative mortality in absolute terms. A recent news release from the American Association for Thoracic Surgery found operative mortality is higher than appreciated, with a risk that persists for at least 90 days and from causes that are as yet unclear.² Contemporary reports suggest that 30- and 90-day mortalities range between 1% and 5% and between 3% and 10%, respectively.³ With SBRT, the risk of death within 90

days for peripheral non-small cell lung cancer is extremely low.³

Avoiding surgical morbidity by using radiotherapy is a well-established strategy and has for a long time been the standard of care in other settings. In laryngeal cancer, radiotherapy is used even though local recurrence is six times higher (12% vs 2%) than with laryngectomy, because salvage laryngectomy ensures that disease-free survival is not affected and voice preservation can be achieved 64% of the time.⁴ Similarly, local recurrence in breast cancer is more than 4 times higher (9% vs 2%) with lumpectomy and radiotherapy versus mastectomy; however, salvage mastectomy ensures that survival is not compromised.⁵

Prospective clinical trials to determine how best to detect local recurrence after SBRT and to evaluate operative mortality with salvage surgery should be the focus of research in the absence of randomized comparative trials.

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