Reply to the Editor:

I thank Dr Senthil for his thoughtful comments on our data comparing recurrence and survival between stereotactic body radiotherapy (SBRT) and surgery. I agree that well-designed prospective trials are needed if we are to advance our understanding of the role of SBRT in the treatment of early-stage non-small cell lung cancer. Although the overall local recurrence rate was 4-fold higher in the SBRT cohort than among all those undergoing resection, from a surgical standpoint we remain concerned that the majority of these local recurrences occurred in patients undergoing sublobar resection, whereas local recurrence was rare with lobectomy, the current standard of care for low-risk patients.

With these issues in mind, we recognize the importance of refining our selection criteria and optimizing our operative technique (in favor of anatomic segmentectomy) in patients most suitable for sublobar resection. Furthermore, we recognize that there is likely a subset of “very high-risk” surgical patients as well. In our previously published data on high-risk patients undergoing sublobar resection in the American College of Surgeons Oncology Group (ACOSOG) Z4032 trial, we demonstrated an extremely high-risk subset with a 2-fold increase in 90-day adverse events (48% vs 24%) with respect to the lowest risk quintile.¹ This may represent the subset of patients with potential equipoise with SBRT treatment of early stage non-small cell lung cancer. With regard to the issue of preservation of pulmonary function with SBRT, although SBRT avoids actual resection, the parenchyma is largely nonfunctional in the treated field, and we have demonstrated that the decrement in forced expiratory volume in 1 second after SBRT is greater than after sublobar resection.¹

Without belaboring the concerns and limitations regarding the current

data on SBRT in this setting, we must move beyond this counterproductive “all or none” debate on the primary treatment of early-stage lung cancer. Treating with SBRT and offering salvage surgery after failures is not a tested strategy, either in trials or in the clinical setting. Treating low-risk patients with SBRT or surgery is investigatory, at best. The notion of having all stage I lung cancer care begin with treatment with SBRT, with surgery only as salvage treatment, is self-serving, without basis, and potentially a setback to our collaborative efforts to define the actual role of SBRT in the treatment of lung cancer.

We can rather focus on collaborative efforts in a number of areas: (1) identification of objective selection criteria for treatment modality in high-risk patients; (2) evaluation of appropriate follow-up imaging and identification of recurrence after treatment with SBRT and surgery; (3) creation of composite end points that include morbidity, overall and cancer-specific mortality, and quality of life assessment, and incorporation of this measure in the selection of treatment; (4) determination of the role of salvage surgery after SBRT treatment; (5) standardization of SBRT and surgical treatment across institutions; and (6) identification of patients with limited life expectancy for whom no treatment may be appropriate. This is the short list of what we need to accomplish, working collaboratively, to improve patient care in this area.

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Reference

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HOW TO OPTIMIZE AN INDIVIDUALIZED STRATEGY FOR ANTIPLATELET DRUG ADMINISTRATION AND DISCONTINUATION MANAGEMENT USING PLATELET FUNCTION TESTING?

To the Editor:

We read with great interest the recently published case-control study by Mannacio and colleagues.¹ Regarding preoperative clopidogrel administration management, the patients were divided into 3 equally matched groups with the aim of evaluating whether individually tailored preoperative clopidogrel discontinuation management according to the platelet function test results might reduce postoperative blood loss and transfusion requirements in patients exposed to clopidogrel in proximity to surgery.¹ In brief, the strategy to guide clopidogrel discontinuation management using platelet function testing significantly reduced postoperative bleeding and blood consumption.¹ In addition, the platelet function testing-based strategy provided a shorter waiting time to surgery after clopidogrel discontinuation than recommended by current guidelines.¹ At present, different types of devices to measure drug-specific platelet reactivity are available. Despite some device-specific advantages and disadvantages, some basic principles in preoperative decision making should inevitably be considered, because they are applicable to each device providing drug-specific platelet function quantification. Their study has certainly added to the current knowledge; however,