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WE ARE ON THE SLOPE TOGETHER

Reply to the Editor:

"If in doubt, give the patient the benefit of the doubt."

—Dr Robert Ginsberg¹

An elderly patient came to our clinic recently. She was a nonsmoking octogenarian with marginal functional status, on 2 L of home oxygen (new from a recent pneumonia related to the lesion), marginal pulmonary function tests, and no diagnosis for a new left upper lobe mass. She had a positron emission tomography scan with mild uptake in the mass and no other sites of disease. Magnetic resonance imaging of the brain was negative. There was no easy way to diagnose. This patient had options with our group that included stereotactic body radiation therapy (SBRT). The lesion could have been benign. Many uncertainties. She opted for surgery.

The patient underwent a short period of prehabilitation. We operated. An intraoperative biopsy showed non-small cell lung cancer (NSCLC), and lobectomy with mediastinal lymphadenectomy was performed. Final path demonstrated a T2aN0 adenocarcinoma. She did well postoperatively. The careful approach by our multidisciplinary team here produced a good result with the best potential for a long-term cure. "If in doubt...."

SBRT is a viable option for many patients with NSCLC. The response to our editorial on the study by Yerokun and colleagues is thoughtfully constructed and strong.^{2,3} Our main message from our editorial on the analysis was effective, as this is drawing attention to an issue that needs careful evaluation.⁴ If one puts aside social media and other dialogue that often accompanies these issues,

we can begin to realize that we are essentially all on the same page. The slippery slope is the practical application of the concepts and data.

In their response to our editorial commentary, Maghanaki and colleagues³ articulate that "By all accounts, practice patterns have already begun to shift and surgical patients are increasingly opting for SBRT." We wholeheartedly agree that it is the duty of radiation oncologists and thoracic surgeons to support the enrollment of patients to the currently active trials that are randomizing patients between resection and SBRT, as indicated in the concluding paragraph of their letter. The concern we have is the fact that patients are driving decisions in the absence of clear data and we as thoracic oncology groups don't have the solid data to advise them appropriately and prevent the paradigm shift. This is not uncommon in our world. No one is arguing about the medically inoperable patient being referred for SBRT in 2017. The concern we have is that NSCLC is being treated in the absence of diagnosis or data with a modality that is increasingly accepted and not all practices are as well-structured to manage these issues. That's the slippery slope and we are all on the slope together.

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