

References

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Does Visceral Pleural Invasion Affect Prognosis in Stage I Non-Small Cell Lung Cancer?

To the Editor:

We read with interest the paper by Huang and colleagues [1]. It is an interesting metaanalysis investigating the role of visceral pleural invasion (VPI) as a prognostic factor in resected stage I non-small cell lung cancer. In particular, the authors focused their attention on VPI effect in relation to tumor size. In fact, some studies suggest that VPI is not influential in tumors smaller than 3 cm, not supporting the upstage to T2a.

Instead, their results showed that VPI was associated with a poorer overall survival and with a higher risk of recurrence in stage I patients. Moreover, VPI was also independent from tumor size and histology type in affecting overall survival and recurrence-free survival. Therefore, they support T2 upstaging in case of VPI independently by tumor size and suggest the use of adjuvant treatment (e.g., for stage II patients) independently by histology.

Our main concerns are the characteristics of patients conclusion in the study. The authors declare that confounders such as type of operation were adjusted, but do not report any data regarding margins and nodal dissection. However, it is a common opinion that the kind of resection, the margin extent, and the hilar nodal dissection are significant in determining overall survival and recurrence-free survival [2, 3]. Furthermore, these data are essential when comparing tumors smaller than 3 cm, because currently many different surgical approaches are usually adopted in their management (open versus video-assisted, anatomic versus nonanatomic resection, lobar versus sublobar resection).

Our second concern is the heterogeneity of VPI diagnostic methods adopted by pathologists in the studies included in this metaanalysis. This is an important bias as confirmed by the authors themselves.

To conclude, Huang and coworkers' results are interesting. However, to obtain conclusive data regarding the prognostic factor of VPI in small tumor, a multicenter prospective study is recommended.

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CORRECTION

Black MC, Trivedi J, Schumer EM, Bousamra M II, van Berkel V. Double lung transplants have significantly improved survival compared with single lung transplants in high lung allocation score patients. *Ann Thorac Surg* 2014;98:1737–41.

In the above-referenced article, the authors note an error in the results section that reads “At 1 and 2 years, respectively, 49% and 27% of patients with a high LAS who received a unilateral transplant were alive, whereas 57% and 32% of patients with a high LAS who received a bilateral transplant were alive.” The text should read “At 1 and 2 years, respectively, 66% and 53% of patients with a high LAS who received a unilateral transplant were alive, whereas 78% and 72% of patients with a high LAS who received a bilateral transplant were alive.” These are the results as depicted in Figure 2 of the manuscript. The authors regret this error.