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Radiation therapy for post-operative recurrence: yes, but only for limited indications



From the authors:

We read the correspondence of Cihoric and colleagues related to our editorial with great interest. Radiation therapy, either alone or in combination with chemotherapy, is a widely accepted treatment modality for post-operative lung cancer relapse. The focus of our editorial was to increase the awareness of possible repeat intervention in this quite limited patient group with generally poor prognosis [1]. Although the overall message of this correspondence is not debatable, the statement that “the available evidence shows that patients with post-resection recurrent nonsmall cell lung cancer (NSCLC) can achieve excellent results when treated with radiation therapy alone, or with radio-chemotherapy” is somewhat misleading as we have several concerns related to the evidence supporting the above statement.

The analysis cited under reference 5 in the correspondence included patients treated at the radiation therapy department in the period 1982–1993 [2]. In this series, both preoperative and post-recurrence work-up was unclear as computed tomography scans only became mandatory after 1988. Selection criteria for initial surgery are unknown, as well as criteria to reject patients with relapse from repeat surgery. With such an inconsistent or unclear preoperative work-up, well before the era of positron emission tomography and mediastinoscopy, it does not seem appropriate to compare survival of patients with isolated bronchial stump recurrences with survival of patients with surgery alone (or combined with other therapeutic modalities) in newly diagnosed T2N0 NSCLC.

Furthermore, comparison of survival of patients with post-surgery recurrence *versus* newly diagnosed NSCLC patients treated with radiation therapy or combined radio-/chemotherapy is not very helpful in optimising a therapeutic approach for cases of post-operative relapse [3].

We agree that combined radio-/chemotherapy is a promising option for patients with a post-surgical recurrence, as in the single-centre study of TAKENAKA *et al.* [4], but studies comparing repeat surgery with radio-/chemotherapy or with radiation therapy alone are missing. Similarly, the results of the systematic review cited under the reference 3 in the correspondence from Cihoric and colleagues, with median survival times of ~28.5 months and a 5-year survival in excess of 30%, emerged from considerations of treatment modalities with radiation therapy alone [5].

In addition, there are some general concerns when comparing surgery with the newly introduced stereotactic radiation therapy: specific pathological diagnosis is not obtained in every case; lymph node evaluation is less rigorously performed; and evaluation of treatment is quite challenging after stereotactic radiation therapy due to the inflammatory response and fibrosis that invariably occur [6, 7]. After complete surgical resection this is more straightforward as there is no remaining disease. For this reason direct comparison between surgery and radiation therapy is not possible [7].

In conclusion, radiation treatment remains an alternative treatment option for post-surgical lung cancer relapse, especially for those patients that are functionally inoperable or technically unresectable. Further evidence is certainly needed to develop more general recommendations for treatment of recurrent disease.



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Radiation therapy remains an alternative treatment option for post-surgical lung cancer relapse

<http://ow.ly/GaM43006HDs>

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Readmission in COPD patients: should we consider it a marker of quality of care or a marker of a more severe disease with a worse prognosis?

To the Editor:

In the January edition of the *European Respiratory Journal*, we read with interest the paper by HARTL *et al.* [1], which evaluated, from the European COPD Audit, patients with acute exacerbation of chronic obstructive pulmonary disease (AECOPD) and the mortality risk during hospitalisation and in the post-discharge period of 90 days. Moreover, the authors evaluate the risk of readmission in a period of 90 days from discharge.

The readmission to hospital that occurs with COPD patients is a many-sided phenomenon, where the complexity of patients and the difficulties with the healthcare systems are often considered as causes [2]. The reasons of readmission may be respiratory and non-respiratory related [2]. Starting from the concept that in COPD patients, like for other chronic diseases with high costs related to discharge (congestive heart failure, acute myocardial infarction and pneumonia), the early readmissions (30-days from discharge) should be considered a marker of quality of care that patients receiving during hospitalisation [3], in USA by the Centres for Medicare and Medicaid Services financial penalties were applied for hospitals with high rates of readmissions [4]. Several interventions have been proposed [5], even if a single disease-specific approach is not recommended [2, 5]; obviously, data about prediction of readmission might be extremely useful [6, 7].

Although the study by HARTL *et al.* [1] focuses on a period of 90 days from discharge and the causes of readmission are not exclusively respiratory related, our recently published long-term observational study [8]