Construcive Remarks Concerning Visceral Pleural Surface Invasion in Non-Small Cell Lung Cancer Patients

To the Editor:

David and coworkers [1] have recently reported a large series of N0M0 non-small cell lung cancer (NSCLC) with visceral pleural invasion (VPI). They concluded that VPI was not associated with survival for tumors smaller than 5 cm, but showed negative effects on disease-free survival for tumors larger than 5 cm. This conclusion prompted us to raise an interesting question: does the varied effect of VPI on survival with different tumor sizes associate with VPI classification?

Patients with VPI can be further classified into two groups, PL1 and PL2, representing patients without and with visceral pleural surface invasion (VPSI). VPSI as an independent factor for poor prognosis and recurrence in NSCLC has been reported [2, 3]. Large tumor size was related to more frequent occurrence of VPSI [2]. Therefore, the correlation of VPI and poor prognosis for large tumors but not small tumors may be related to more frequent occurrence of VPSI in large tumors.

The poor prognostic effect of VPSI may be explained by the rapidity with which lung cancer cells in a subpleural location invade the pleura and disseminate throughout the pleural cavity. Once these cells exfoliate into the pleural cavity, preformed stomas that connect subpleural lymphatics with the pleural space could account for the systemic dissemination.

Concerning the standard definitions and evaluations of VPSI we previously reported [2], we would like to share with readers more detailed descriptions for processing the specimens with VPSI. Despite careful inspection and sampling of the retracted pleural surface with all for section of the retracted areas, serial microsections for definitive diagnosis are recommended to avoid the probably missing microscopic foci of VPSI. Immunohistochemical studies of thyroid transcription factor-1 protein and calretinin instead of elastic retracted areas, serial microsections for definitive diagnosis are recommended to avoid the probably missing microscopic foci of VPSI. Immunohistochemical studies of thyroid transcription factor-1 protein and calretinin instead of elastic

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Could Difference of Smoking Rate Between Men and Women Affect the Risk Difference of Acute Kidney Injury According to Sex?

To the Editor:

We have read the article by Mehta and colleagues [1] that showed women had a lower risk of acute kidney injury (AKI) than men at lower nadir hematocrit on cardiopulmonary bypass. In this study, the researchers considered the relationship between several preoperative risk factors like diabetes mellitus and AKI in men and women separately. How about smoking?

Smoking might increase risk of kidney failure, especially in men [2]. Although the pathophysiology of the association between smoking and kidney failure has not been fully revealed, smoking affects endothelial cell function, leading to vasoconperfusionstriction and vascular damage [3]. Reactive oxygen/nitrogen species generated from smoking might alter erythrocyte membrane physicochemical properties, changing the tissue [4]. The formation of carboxyhemoglobin after smoking causes a left shift of the hemoglobin-oxygen dissociation curve [5], which cause changes of tissue perfusion. The smoking prevalence of men was higher than women in Italy [6]. In conclusion, we should ask whether the smoking rate was different between males and females. Smoking could affect kidney function and tissue perfusion, so it acts as a bias in a study that evaluates whether AKI risk is lower in women than in men.

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Sternal Wound Infection and Bilateral Internal Mammary Artery Harvest: There’s More to It Than the Harvesting Technique
To the Editor:
I read with great interest the metaanalysis by Dai and co-workers [1] and congratulate them on publishing the largest metaanalysis to date of observational studies reiterating that bilateral internal mammary artery (BIMA) grafting bears an intimate relationship with the increased risk of sternal wound infection. More important, based on the findings of their analysis they endorse that as skeletonized BIMA is confirmed to carry a lower risk of sternal infection than pedicled BIMA, it should be the procedure of choice. Unfortunately, like several other metaanalyses on the subject, this one has important limitations and appears to oversimplify the problem.

The researchers claim that important statistical heterogeneity among studies was not observed yet the differences in terms of operative technique and volume may have led to an influence of clinical heterogeneity not picked up by the metaanalysis. Other factors that would have influenced the results but were not well reported in the included studies and thus not taken into consideration were the prevalence of obesity, chronic pulmonary obstructive disease, excessive use of bone wax or diathermy, quality of operative antisepsis prophylaxis, sternal closure technique, multiple transfusions, glycemic control in diabetic patients, and the way the patient is prepared for surgery (shaving and cleaning and the timing of both before the operation), as well as bacterial flora of each center.

Cardiac surgery is a specialty that has its fair share of misperceptions and myths. One such myth is the association of an increased rate of sternal wound infection with the use of pedicled BIMA in general and in diabetic patients in particular. Lack of evidence from randomized controlled trials in this area may be one of the reasons perpetuating this myth. However, lack of attention to detail and failure to address the several modifiable risk factors associated with sternal wound infection after pedicled BIMA grafting are the predominant causes that have prevented universal adoption of BIMA grafting. We have recently reported similar sternal wound complications with pedicled BIMA harvest, the default strategy at our institution, in diabetic patients and nondiabetic

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