

INVASIVE MEDIASTINAL STAGING

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The lung cancer staging classification describes the anatomical extent of malignant pulmonary tumors in terms of three parameters: tumor (T), nodal status (N) and metastasis at pleural fluid, contralateral lung or distant organs(M)[1]. The treatment of non-small cell lung cancer (NSCLC) is determined by accurate definition of the stage[1]. Survival curves of the patients with non-small cell lung cancer at different stages show that, the patients with stage 1A to stage IIIA(T3N1) should be amenable to resectional surgery [2]. The patients with N2 or N3 disease should be referred to multimodality treatment [3,4,5]. Even for the patients who had chemoradiotherapy the surgical resection has been proven to be futile if there is recalcitrant N2 or N3 disease[6]. If there are no distant metastases, the status of the mediastinal lymph nodes is important. Although imaging studies can provide some guidance, in many situations invasive staging is necessary. In patients with extensive mediastinal infiltration, invasive staging is not needed [3,4] (Figure 1). Those patients should be referred to chemo/radiotherapy[3,4,5].

In patients with discrete node enlargement, staging by computerized tomography(CT) or positron emission tomography (PET) scanning is not sufficiently accurate (Table 1). The sensitivity of various techniques varies between 55-80% which is suboptimal. Although negative

predictive value of PET-CT is 91% as a result of a systematic review[4], positive predictive value is near a tossing a coin(i.e.58%)! For these reasons, one should not rely on CT or PET-CT in T2-T4 tumors[2-5]. Patients with peripheral T1 tumor (preferably non-adenocarcinoma histology) without mediastinal lymph node involvement on PET-CT, will be offered to resectional surgery without any invasive mediastinal staging modality since the false-negativity rate is below 5%(Figure 2)[4,5,8,9]. When PET scan is implemented, the rate of overlooked N2 disease is expected to be below 10% [8,9].

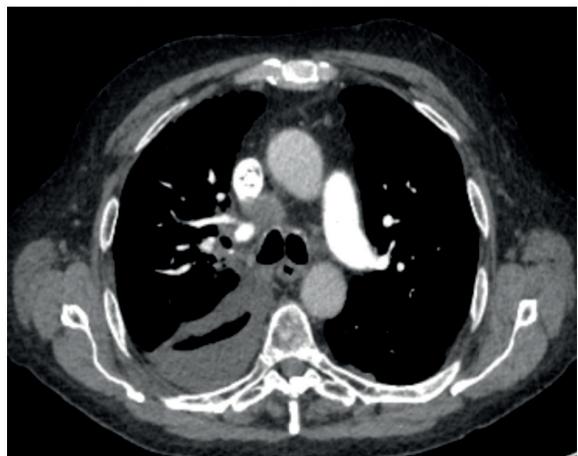


Figure 1. A patient with right upper lobe tumor adjacent with right paratracheal lymph node. In these patients, there is no need for mediastinal lymph node biopsy provided that the tumor is diagnosed.

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utilized for assessment of resectability of the tumor before resectional surgery[48]. A phase 2 trial concluded that mediastinal restaging after neoadjuvant chemo/radiotherapy done by video-thoracoscopy is feasible and provided pathologic specimens of ipsilateral lymph nodes[49]. However, they also concluded that, restaging was limited by radiation to the lower paratracheal region.

CONCLUSION

Mediastinal staging should be performed in almost all NSCLC patients except the ones with peripheral cT1N0M0 squamous cell tumors[3]. Figure 13 shows mediastinal lymph nodes and staging procedures that can be used to take excisional or incisional biopsy of those lymph nodes. We recently were able to show that an appropriately accomplished pre-resection lymph node staging for the patients with NSCLC seems to be effective, helps to select best candidate who can benefit from surgery and provides higher survival following resection[50]. Every surgeon should select staging methods depended on radiologic and scintigraphic (PET-CT) evaluation of the par their ability, experience, patient's status, previous operations and morbidity, available instruments at the department.

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