pressure ventilation, lower lengths of hospital stay and intensive care unit stay, greater parental satisfaction, and potentially decreased incidence of postoperative morbidity. But it is of paramount importance to identify patients who are not candidates for early tracheal extubation and to continuously improve their treatment.

Finally, with the shift in practice toward early extubation in children undergoing cardiac operations, we are faced with a population of patients who now require sedation and analgesia during their early recovery phase after cardiac operations. In addition, as our study has shown, there might be a role for delirium that may be defined in the adult population but is not clearly understood in the pediatric patients. Whereas different studies have shown that early tracheal extubation is safe and achievable, robust postextubation management strategies are keys to successful outcomes.

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T3 Non-Small Cell Lung Cancer: Should Multimodal Therapy Be Different for Each Presentation?
To the Editor:

We read with interest the article by Jeon and colleagues [1] about the different prognoses for patients affected by T3 non-small cell lung cancer (NSCLC). The authors found that adjuvant chemotherapy was one of the most important independent prognostic factor for disease-free survival (DFS) in each group of patients with stage T3 disease.

However, patients with chest wall involvement had a 5-year DFS of only 36% (vs 55% of patients with tumors within 2 cm of the carina), and in the literature the best approach for these tumors has not yet been well defined, nor has a multidisciplinary approach with multimodal therapy been shown to be promising [2, 3].

By contrast, the proposed eighth edition of the TNM staging system for lung cancer [4] changes the stage for tumors with involvement of the main bronchus from T3 to T2, despite the distance from the carina, leaving in the T3 group tumors with chest wall involvement, separate nodules in the same lobe, or dimensions larger than 5 cm and less than 7 cm.

In our experience, in a multicenter cohort of T3N0 NSCLC patients with chest wall involvement, we found that patients with pathologic downstaging after induction therapy experienced better overall survival (OS) and DFS compared with patients with stable disease: 2-year DFS 80% versus 42.9% (p = 0.03) and 3-year OS 100% versus 50% (p = 0.17).

We think that this presentation of T3 is an optimal subject for induction therapies like chemoradiotherapy for the possibility of determining a precise field of action and obtaining a down-staging or a tumor shrinkage that permits less extensive resections, increasing the distance of the neoplasm to the surgical margins.

On the other hand, patients with separate nodules in the same lobe may benefit from induction chemotherapy, reducing the spread of metastasis and reserving different adjuvant treatments on the basis of the mediastinal pathologic stage.

So, as confirmed by the coming eighth edition of TNM staging system, T3 tumors represent a heterogeneous disease, and maybe multimodal therapies could be tailored for each subgroup.

On the basis of the data reported, we would really appreciate the authors’ reflections on, and reaction to, the aspects debated.

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