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Authors' Reply

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Thank you very much for your interest in our study published recently in *Respiration* [1].

Regarding your comment [2] about the thoracic duct obstruction, we are sure that you understand that even if there were any such case, it would not change anything in the work-up and treatment of the patient. Indeed, the right treatment would have been the treatment of the underlying disease (neoplasm) after the histological confirmation. There was no case of chylothorax (otherwise it would have been reported). In addition, the patients with mediastinal nodes observed during thoracoscopy had biopsies made of these nodes during the procedure.

As we discussed in our study, the neutrophil-to-lymphocyte ratio has been associated with worse survival in many types of cancer. We consider the mechanisms concerned to have been sufficiently explained and discussed in our published paper [1] as well as in the international literature [3–6]. In addition, patients presenting with significant comorbidities that can affect short-term survival and therefore the outcome of thoracoscopy, such as hypoventilation or unstable cardiac disease, are not suitable for any interventional procedure [7]. Regarding the subgroup analysis in lung cancer patients, as you probably noticed in our table 1 [1], there were 34 patients with non-small cell lung cancer and 6 with small cell lung cancer. To perform subgroup analyses by combining histological subtypes with performance status and all assessed parameters would have resulted in groups with very few patients, with the result that no reliable interpretations could have been made and no useful conclusions could have been drawn.

Indeed, as you mentioned in your letter, we designed our study to include only patients in whom pleural effusion was the present-

ing syndrome, and we therefore excluded all patients with an already known carcinoma who secondarily developed pleural effusion [1]. It is a fallacy that all patients with malignant pleural effusion are likely to have poor survival. This fallacy has arisen from the fact that most physicians and therefore most published studies consider all these patients in the same way. However, the real situation is different, as we showed in our study [1]. Taking into account that patients with a primary tumor sensitive to any treatment could benefit from this treatment, medical nihilism has no place. Finally, the 'take-home message' from our study is that physicians should differentiate this patient population from patients with an already known neoplasm that developed pleural effusion during the course of the disease, due to the potential for relapse of the disease and/or resistance to therapy.

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