Respiration 2018;96:204
DOI: 10.1159/000489889

The Role of Endobronchial Treatment for Bronchial Carcinoid: Considerations from the Thoracic Surgeon's Point of View

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Dear Editor,

We read with interest the article by Reuling et al. [1] and van der Heijden's related editorial comment [2] on the role of endobronchial treatment (EBT) for bronchial carcinoids.

Reuling et al. [1] reported on a retrospective, high-volume, single-center experience of EBT for 125 typical and atypical carcinoids over a 25-year period, concluding that patients with purely intraluminal carcinoids with a diameter <20 mm on computed tomography (CT) are good candidates for EBT, regardless of the histological grade.

In the wake of this report, van der Heijden [2] proposes modifying the existing guidelines of the National Comprehensive Cancer Network (NCCN) and the European Neuroendocrine Tumour Society (ENETS) – both recommending surgical resection as the treatment of choice for most localized carcinoid tumors – suggesting that EBT should be the first-line treatment for intraluminal typical carcinoids <20 mm.

Although intriguing and scientifically stimulating, the reported conclusions present several oncologic, methodologic, and technical biases that should be thoroughly evaluated before any proposal can be formulated to modify the current guidelines.

Firstly, Reuling et al. [1] report a 72% success rate of EBT for intraluminal tumors with a diameter <20 mm, defining successful treatment as the absence of residual disease during the first 2 years of CT and bronchoscopy follow-up after EBT. No data are provided on the overall survival. However, it is well-known that patients diagnosed with typical carcinoids – and properly treated – experience a long survival, with multiple reports citing 5-year sur-

vival rates of 88–92% [3]. For this reason, it is doubtful whether a procedure with a much lower success rate than the recognized standard treatment can be proposed as a first-line therapy. Moreover, the 5- and 10-year survival rates of EBT are currently unknown, and this is of paramount importance in such an indolent and low-grade disease.

Secondly, although the authors focus on purely intraluminal tumors assessed by CT scans, it is important to recall that only 5–10% of all bronchial carcinoids are polyp-like structures without extension through the cartilaginous wall [4]. Repeat bronchoscopy and CT scans performed 6 weeks after EBT may offer a good short-term evaluation of the radicality achieved, but local persistence cannot be ruled out, especially in lesions with large implant bases despite being polypoid and purely intraluminal.

In conclusion, based on the results found by Reuling et al. [1], EBT could be reserved for exceptional cases or a subgroup of patients not eligible for radical surgery [5, 6]. We do not believe that their findings constitute robust enough evidence to support a request for guideline modifications. Longer follow-up periods and clear data on the overall survival are needed to further explore the curative oncologic potential of EBT.

References

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