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Regular follow-up for patients irradiated for early stage nonsmall-cell lung cancer too!

To the Editor:

It was with interest that we read the recent article by EGERMANN *et al.* [1] on the outcome of regular follow-up in patients with nonsmall-cell lung cancer (NSCLC) treated with curative resection, including cost-effectiveness analysis. We wholeheartedly agree with the conclusions of the study, but would like to extend this observation to another subset of patients, namely those with technically operable, but medically inoperable early stage NSCLC, usually treated with radiation therapy (RT) alone [2–5]. There are a number of similarities and differences between these two patient groups.

First, contrary to surgical series, RT patients developing metachronous second primary lung cancer (mSPLC) are not treated differently from those relapsing locally from their first malignancy. Owing to pre-existing comorbidities, they are always treated the same way (with RT) [6]. While some of those patients relapsing locally may be treated palliatively [7, 8], a number of them may be treated curatively, particularly those with recurrences confined to the bronchial stump [7–10]. In the latter, high-dose RT alone can achieve median survival times of $\leqslant$30 months and 5-yr survival rates of $\leqslant$30% [7, 9, 10].

Secondly, in contrast to surgical series where second curative resections in mSPLC are rare clinical events, a second RT course in mSPLC diagnosed using the same criteria by MARTINI and MELAMED [11] achieved 5-yr cause-specific and overall survival of 53 and 30% respectively, in patients with Stage I/II NSCLC [6]. In addition, there were neither RT-related treatment deaths, contrasting (30-day) preoperative mortality of 13% in the series of EGERMANN *et al.* [1], nor significant (high-grade) acute or late toxicity, due to the "limited" RT treatment fields used in the patients with mSPLC [6]. RT results in this patient population are, therefore, at least comparable with those of surgical series [12–16] of second lung cancer, with a resectability rate of ~50%, median survival times of 1–2 yrs, and 5-yr survivals ranging from 4–32% [17].

Thirdly, while we agree with EGERMANN *et al.* [1] that the outcome of their patient population may have been burdened by advanced age and pre-existing comorbidities, this was even more the case for the RT-treated patients who were not surgical candidates, with the exception of a few patients who refused surgery for their initial early NSCLC [2–5]. We have used a very similar follow-up approach to that of EGERMANN *et al.* [1] in our patient population, and, although we did not perform cost-effectiveness analysis, we are almost certain that the same would have happened with RT.

Finally, we think that more clinical research should be performed to identify patients who may be at greater risk for developing secondary cancer or cancer that is recurring. Identification of various prognostic factors, such as clinical (patient or tumour-related), laboratory and "biological", could be included, if not before, then at least as part of a comprehensive follow-up plan, in order to direct some or all of the follow-up procedures towards the subset of patients at greatest risk for developing either metachronous second primary lung cancer or local recurrence. Although this may decrease the cost-effectiveness of any follow-up programme in this patient population, it would be instantly rewarding as it would increase the ability to diagnose such patients earlier, and, therefore, offer them more curative approaches, leading to more life-years gained, which is an ultimate goal in this disease.

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