CORRESPONDENCE

Lung cancer resection rate is related to survival

Treasure and colleagues[1] provided a welcomed counterpoint to the belief that resection rate should go up in England. However, we feel the editorial is intentionally controversial and biased against the role of surgery. In particular, the authors question the relationship between resection rate and outcome but fail to cite the recent evidence that relates resection rate to survival in the UK: that the small excess mortality from operating in higher-risk groups was more than justified by the increase in overall survival from lung cancer.[2]

In terms of treatment, two factors affect overall survival: effectiveness of the treatment and availability of effective treatment to those who would benefit from it. In terms of the latter, evidence suggests the improvement in the resection rate has been made by reducing unwarranted variation in treatment rather than by increasing operations on unresectable cases.[3] If there is unwarranted variation, then someone must be disadvantaged. Furthermore, there is still plenty of room for improving resection rates before the point where 'harm outweighs benefit' is reached.[2]

In terms of effectiveness of treatment, just as mastectomy has evolved, surgical techniques for lung cancer have undergone refinement. Video-assisted techniques avoiding a thoracotomy have reduced the harm of operations and improved outcomes.[4] Compared to historical results, the outcome of operations in the less fit patient today is much better than it was. At the same time, the question of whether refinements in non-operative techniques such as stereotactic body radiation therapy and radiofrequency ablation might offer better outcomes than surgery is not being neglected—there are a number of randomised trials being conducted to answer these questions. Nevertheless, recruitment into these trials has not been easy, and many trials such as ROSEL have had to be terminated early. For some questions, the randomised evidence may be too costly and difficult to obtain.

We appreciate the succinct question Treasure and his other 'Devil's advocates' proposed, but in their words, 'I think you'll find it's a bit more complicated than that…'. Today, the question is not whether surgery for lung cancer is effective, but which surgery is best for the patient, how that compares to the most effective treatments in other modalities, and how to ensure the best treatments are delivered consistently throughout the country. We hope that Treasure's editorial will not be accepted unchallenged and that the current momentum towards higher resection rates in lung cancer will not be stalled.

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