Reply

To the Editor:

We are indebted to Dr Jaretzki and colleagues for their comments and suggestions concerning our report. In addition to pointing out a definite shortcoming of that study, ie, that preoperative pulmonary function status was not defined, they criticize our protocol for the preoperative preparation of patients and underline the high incidence of respiratory complications. Further, they express doubts as to whether improving perioperative management might reduce the incidence of such complications.

During the decade corresponding to the study period, the recording of respiratory variables immediately before operation was obligatory according to the preoperative management protocol adopted by our institution. This screening was performed even on patients undergoing operation with the trachea open. Only the stratification by forced expiratory volume in 1 second (FEV_1) is mentioned here. Respiratory insufficiency was ascertained in 52 (20%) of 266 patients with an FEV_1 greater than 60%, in 13 (32%) of 41 patients with an FEV_1 higher than 40%, and in 6 (35%) of 17 patients with an FEV_1 lower than 40%.

Like others, we are aware of the widely known close correlation between preoperative status and postoperative complications rate; also, we acknowledge the importance of having patients optimum condition for surgical intervention [1]. This, however, can be achieved by a variety of strategies and methods that are undoubtedly dependent on financing. In Hungary, plasmapheresis was introduced for the management of myasthenia gravis as early as 5 years after its first publicized use in the literature [2]. High costs and meagerness of resources have precluded extensive use of this procedure for many years. Pretreatment with intravenously administered immunoglobulin g before thymectomy has been omitted for similar reasons. A recent review of the literature [3] showed no recent decline in the importance of immunosuppression. Nevertheless, this treatment is no substitute for plasmapheresis; rather, these two therapeutic modalities supplement each other. The truth of this statement is illustrated also by the following: "The patients should be as free of symptoms as possible at the time of surgery, especially free of signs and symptoms of oropharyngeal and respiratory weakness, using plasmapheresis and immunosuppression when necessary" [4].

Our clinical routines and approach to the surgical treatment of myasthenia gravis have changed substantially compared with those reflected in the retrospective analysis of the decade-long period covered by our study. Indications, preoperative preparation, and perioperative management have all been improved. Shortage of space prevents us from discussing here the changes that have resulted in a reduction in the rate of respiratory complications from 22% to 6%, the rate for the 171 patients undergoing extended transsternal thymectomy for myasthenia gravis performed by us since 1996.

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Late Recurrence After Resection of Stage I Lung Adenocarcinoma

To the Editor:

In 1999, Lenner and coworkers [1] reported cases with late recurrence after resection of stage I lung cancer. Late recurrences in early-stage lung cancer have been rarely observed more than 10 years after complete resection [1, 2]. The following report is of a stage I lung cancer patient with late recurrence 12 years after complete resection.

In September 1989 a 53-year-old woman was admitted for a small nodular lesion in the right lower lobe incidentally noted on a screening chest x-ray film. She was totally asymptomatic with an unremarkable physical examination. She had no remarkable medical history and had never smoked. Chest radiography and computed tomography (CT) scan showed a 2-cm nodule in S^6. Bronchoscopic biopsy revealed a well-differentiated papillary adenocarcinoma. No distant metastases were detected. Right lower lobectomy and lymph node dissection were performed, with a pathologic stage of T1N0M0. Careful review of serial chest radiographs spanning 12 years revealed no lesions believed to be recurrence. In February 2002, however, elevated serum CEA (31.9 ng/mL) was found incidentally on mass screening. On chest CT scan multiple small nodular opacities up to 1 cm in both lungs were discovered. Mediastinal lymph nodes were not enlarged. Workup included CT scan of the abdomen, bone scintigram, brain magnetic resonance imaging, endoscopy, barium enema, gynecologic examination, gallium scintigram, examination of thyroid and breast, and other blood tests, the findings of which were normal. The patient underwent a thoracoscopic lung biopsy in May 2002. The histologic appearance of the small nodular opacities were similar to that of the original lung adenocarcinoma. No treatment was offered, and the patient remained in stable condition for an additional 2 months.

A generalization accepted in the treatment of cancer assumes that a cure is present if there is freedom from disease for 5 years. This concept may apply to the majority of cases of lung cancer but rare cases do recur after many years of disease-free survival. Therefore recurrence of lung adenocarcinoma 12 years after complete resection is almost unique. This observation suggests either a long period of dormancy of residual lung adenocarcinoma cells prior to reinitiation of proliferative activity or the presence of a more slowly growing population of residual cells. It is interesting that in both patients reported by Lenner and colleagues as well as in the present case histologic type was well-differentiated adenocarcinoma and that the first site of late recurrence was lung [1]. Metastases in sites other than lung were not found in these 3 patients. Clues to the mechanism of late recurrence may exist in this clinocopathologic information. Whatever mechanism is involved, it is clear that complete

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