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Video-mediastinoscopy is still the gold standard

A video-mediastinoscopia é ainda o gold-standard

Dear Editor,

We read with great interest the article by Bugalho et al., entitled ''Endobronchial ultrasound-guided transbronchial needle aspiration for lung cancer diagnosis and staging in 179 patients''[1] as well as the editorial by Herth entitled ''Access to the mediastinum—The standard has changed''.[2]

In fact, for patients with lung cancer, despite improvements in the accuracy of imaging modalities over the last decade, invasive mediastinal lymph node staging remains necessary in cases of mediastinal lymph node enlargement, positron emission tomography (PET) positive mediastinal and/or hilar lymph nodes and/or a centrally located tumor.[3] For a long time, cervical mediastinoscopy has been considered the gold standard in mediastinal staging, given the high negative predictive value (NPV) if well performed. However, during the last decade, oesophageal ultrasound-guided fine needle aspiration (EUS-FNA) followed by endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) has emerged as a minimally invasive alternative, reducing the need for a cervical mediastinoscopy as a first-line staging procedure. Nevertheless, when the result of endoscopic staging appears negative, a subsequent mediastinoscopy is currently recommended to exclude mediastinal lymph node metastases in patients with clinical suspicion.[2] But, since the sensitivity of EBUS-FNA seems to exceed that of mediastinoscopy,[4] there is a tendency to cut down on the need for surgical confirmation. Accordingly, in routine practice an additional mediastinoscopy is often regarded as overdone. However, only recently the combination of endosonography followed by mediastinoscopy was shown to be more accurate in mediastinal nodal staging than just mediastinoscopy alone. In patients with non-small-cell lung cancer and an indication for mediastinal staging, performing a cervical mediastinoscopy after a negative result of endosonography reduced the number of futile thoracotomies by 50%. Overall, an average of 8.8 patients had to undergo an additional mediastinoscopy to find one false-negative result of endosonography, but when only patients with suspicious mediastinal lymph nodes on FDG-PET are taken into account, this NNT comes down to 6.1 patients.[5]

We agree with Dr. Herth. The standard has changed. In fact, EBUS and EUS should be used in conjunction with PET and considered as an alternative to mediastinoscopy. However, the gold standard is still video-mediastinoscopy, because in patients with a high probability of mediastinal metastases, a cervical mediastinoscopy should not be omitted after a negative result of endosonography, not even when the aspirate seems representative, based on the presence of a sufficient number and maturation of lymphocytes.

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