



Original article

Surgical Treatment of Lung Cancer With Synchronous Adrenal Metastases: Adrenalectomy First[☆]



Fernando Pardo Aranda,^{a,*} Itziar Larrañaga Blanc,^a Joaquín Rivero Déniz,^a Juan Carlos Trujillo,^b Arantxa Rada Palomino,^a Esteban García-Olivares,^a Ramón Rami Porta,^c Enrique Veloso Veloso^a

^a Servicio de Cirugía General y del Aparato Digestivo, Hospital Universitario Mutua Terrassa, Terrassa (Barcelona), Spain

^b Servicio de Cirugía Torácica, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain

^c Servicio de Cirugía Torácica, Hospital Universitario Mutua Terrassa, Barcelona, Spain

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Introduction: The aim of this study is to present our patients with lung cancer and synchronous adrenal metastases treated with a reversal approach: starting with adrenalectomy and doing the lung resection second.

Methods: A total of 108 laparoscopic adrenalectomies were performed, and we analyze a consecutive series of 10 patients with isolated adrenal synchronous metastases from the lung, surgically treated in a sequential way. All patients underwent staging mediastinoscopy, and patients with positive lymph nodes were primary treated with chemotherapy. We analyze: postoperative morbidity, length of stay, time between the 2 surgeries, survival free progression and global survival. Survival analysis was performed by the Kaplan–Meier method.

Results: Mean age: 56.8 (41–73) years old. Of the total, 8 patients were surgically performed by laparoscopy. Metastases average size: 5.9 (3–10) cm. Days between the 2 surgeries were 28 (12–35) days. No morbidity after adrenalectomy. Length of stay was 4.3 (3–5) days. Disease-free survival at 2 years was 60%, the 5-year overall survival was 30%, with a median survival of 41.5 (0–98) months.

Conclusions: Adrenalectomy involves no significant morbidity and can be performed safely without delaying lung surgery, and allows us to operate the primary lung tumor successfully as long as we ensure complete resection of the adrenal gland. A multidisciplinary oncology committee must individualize all cases and consider this therapeutic approach in all patients with resectable primary tumor and resectable adrenal metastases.

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* Corresponding author.

E-mail address: fparanda@gmail.com (F. Pardo Aranda).

Tratamiento quirúrgico de metástasis suprarrenal sincrónica de cáncer de pulmón: adrenalectomía primero

RESUMEN

Palabras clave:

Metástasis suprarrenal sincrónica
Carcinoma pulmonar no microcítico
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Introducción: El objetivo de este estudio es presentar nuestra serie de pacientes con carcinoma pulmonar y metástasis única suprarrenal sincrónica tratados de manera secuencial inversa: primero adrenalectomía y después resección pulmonar.

Métodos: Del total de 108 adrenalectomías laparoscópicas transperitoneales realizadas se analiza de manera retrospectiva una serie consecutiva de 10 pacientes diagnosticados de tumor primario de pulmón con metástasis suprarrenal sincrónica tratados de manera secuencial inversa. A todos se les realizó mediastinoscopia de estadificación; aquellos con metástasis ganglionares recibieron inducción. Las variables analizadas fueron: morbilidad tras adrenalectomía y tras resección pulmonar, estancia hospitalaria, tiempo entre ambas intervenciones, intervalo libre de enfermedad y supervivencia global. La supervivencia se analizó según el método de Kaplan-Meier.

Resultados: Edad media: 56,8 años (rango: 41-73). Del total, 8 casos se intervinieron por laparoscopia. Tamaño medio de la metástasis: 5,9 cm (rango: 3-10). Tiempo medio entre ambas intervenciones: 28 días (rango: 12-35). No hubo complicaciones tras la adrenalectomía. Estancia media: 4,3 días (rango: 3-5). La supervivencia libre de enfermedad a los 2 años fue del 50% y la supervivencia global a los 5 años fue del 30%, con una supervivencia global mediana de 41,5 meses (rango: 0-98).

Conclusiones: La adrenalectomía para metástasis de carcinoma pulmonar tiene baja morbilidad, no retrasa la resección del tumor primario y permite realizar la resección pulmonar una vez asegurada la resección completa de la metástasis. Por tanto, a falta de ensayos clínicos, un comité multidisciplinar debe considerar de forma individualizada esta opción terapéutica para todos aquellos pacientes en quienes la estadificación clínica de su carcinoma indique que tanto el tumor primario como la metástasis pueden extirparse de forma completa.

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Introduction

In recent years, it has been demonstrated that local curative treatment of localized metastases provides better survival than systemic treatment with chemotherapy.^{1,2}

Several types of tumor metastasize to the adrenal glands, and in some 40% of cases the origin is non-small-cell lung carcinoma. However, the isolated presentation of adrenal metastasis represents only 1%-4%, and these are the cases that will obtain a greater benefit from surgical resection.³

Proper preoperative diagnostic studies are necessary because the finding of an adrenal mass in patients diagnosed with lung cancer does not necessarily represent a metastasis. Some 5% of the general population have benign adrenal adenomas.⁴ Taking the definition of pulmonary synchronous metastases as those diagnosed at the same time as primary pulmonary tumors, we present our series of patients treated in inverted sequence: first the metastasis, and then the primary tumor.

Methods

We present a descriptive study of a consecutive series of 10 patients with synchronous adrenal metastases of pulmonary

origin as the only metastatic site. The patients were treated surgically in reverse sequential order at a single hospital from 1991 to 2010. Our initial experience in 5 patients was previously published.⁵

Clinical staging was performed with posterior-anterior and lateral chest radiographs, blood count and blood biochemistry (including at least glycemia, total bilirubin, liver enzymes, calcium, creatinine and alkaline phosphatase), fiberoptic bronchoscopy, and computed tomography (CT) scans of the chest and upper abdomen, both with contrast. From 1991 to 2000, bone scans were performed systematically. As of 2001, these were replaced by systematic positron emission tomography (PET) scans. All patients with right lung carcinomas underwent staging mediastinoscopy, with left parasternal mediastinotomy or extended cervical mediastinoscopy if the lung carcinoma was on the left. Patients with mediastinal lymph node metastases received induction therapy, after which they were reassessed with a second mediastinoscopy to establish or rule out the definitive surgical indication, as shown in Fig. 1.

Operability was assessed with anamnesis and physical examination, electrocardiogram, spirometry and diffusing capacity of the lung for carbon monoxide (DLCO). Those patients with a forced expiratory volume in the first second (FEV₁) or DLCO below 80% were studied with a 6-min walk test or by climbing stairs; if results were suboptimal, the study was completed with ergometer testing. Quantitative

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