Clark and a left turn on Main Street; I could have turned right on Lewis and two blocks later turned left on Main. But the former route goes past the ice cream shop. Banana cream pie ice cream is worth the slight, two-minute delay—trust me. Similarly, in palliative care, it remains unproven that a quality measure not on the Measuring What Matters list, or slightly modified versions of the chosen measures, would be more appropriate than those included. Such a conclusion would require a robust evidence base linking adherence with other specific measures to improvement in outcomes. The infrastructure to continuously test and validate new measures is still in its infancy but is the focus of many health service researchers in the field. This is the near-term future.

Importantly, this is the first iteration of this effort, with updates planned. The 10 measures chosen represent important signposts along the journey toward high-quality palliative care. Naturally, as new side streets are built (new evidence), tolls added to roads along the way (new barriers), and new favorite beaches identified (shifting definitions of high-quality care), we should remain vigilant to iteratively evolve the roadmap toward an end where all with serious illness receive the care they deserve.

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Palliative Neck Surgery in Metastatic Lung Cancer: A Case Report

To the Editor:

Metastases in cervical lymph nodes from distant primary (nonhead and neck) tumors are rare but may be seen across a wide spectrum of cancer types, including lung cancer.[1] Because the disease is often widespread at this stage, adequate palliative management is essential. Surgical management has always been a point of discussion in palliative care.[2] To increase the awareness of this approach in the palliative care of patients with non-small cell lung cancer (NSCLC) and cervical lymph node metastases, we present a case in which a symptomatic supraclavicular lymph node was surgically removed for palliative purposes.

Case

In February 2014, a 55-year-old woman was referred to the pulmonologist because of complaints suspicious for lung cancer. Positron emission tomography/computed tomography (CT) scans showed a malignant process of the lung with positive ipsilateral hilar and subcarinal lymph nodes and an enlarged left adrenal gland. After staging, which included bronchoscopy, mediastinoscopy, endoscopic ultrasound, and a magnetic resonance imaging scan of the cerebrum, the tumor was classified as a highly probable cT2N1M0 lung carcinoma. Surgical intervention with curative intent was advised by the multidisciplinary cancer board. Via video-assisted thoracoscopic surgery, a lobectomy of the right inferior lobe was performed, accompanied by an ipsilateral lymph node dissection and perioperative mediastinal and subcarinal staging. Pathology revealed a pT2N1M0 NSCLC (histologically classified as an adenocarcinoma). Adjuvant chemotherapy was advised, but, three weeks after surgery, an enlarged, suspicious, supraclavicular lymph node was found. Incisional biopsy revealed a metastasis of the NSCLC, with central necrosis, indicating rapid progression. A CT scan was done for restaging, which, in addition to the supraclavicular tumor (Fig. 1), showed a contralateral pulmonary metastasis and progressive growth of the adrenal gland. Genetic analysis of the tumor revealed Kirsten-rat sarcoma (K-RAS) oncogene positivity and negative anaplastic lymphoma kinase (ALK) mutation. After careful consideration of the risks and benefits, the patient declined conventional palliative chemotherapy.

The patient had a large, visible, ulcerating, and painful tumor just above the clavicle (Fig. 1). The multidisciplinary team recommended surgical removal of the supraclavicular tumor, with palliative

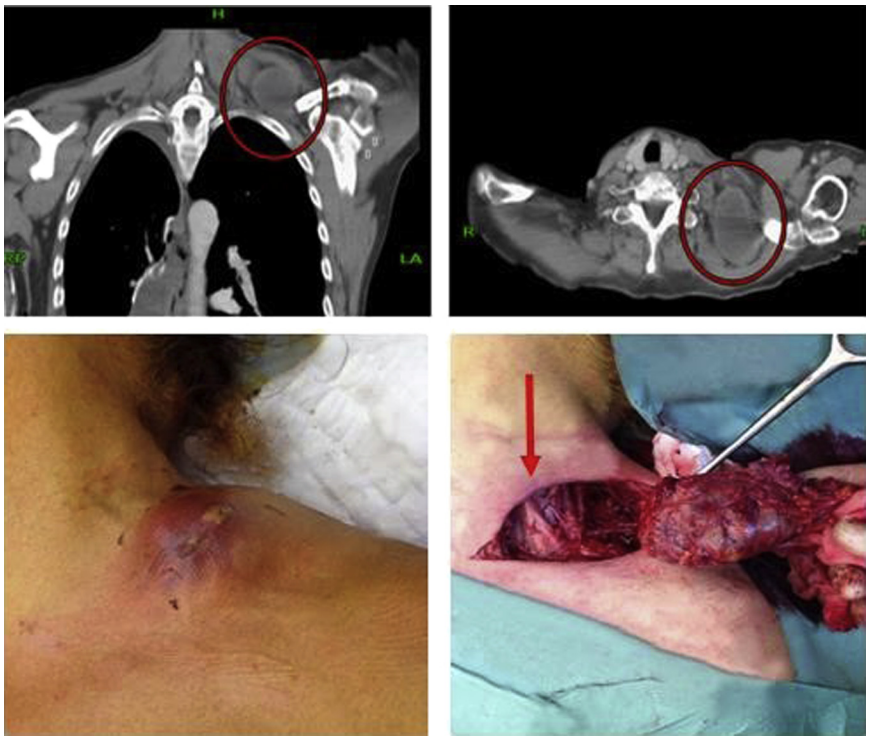

Fig. 1. CT imaging of the supraclavicular lymph node (within the red circles) (above) and intraoperative pictures of the lesion and localization (the brachial plexus indicated with a red arrow) (below).

intent. The tumor was removed by a selective neck dissection. Direct examination of nodal Levels 4 and 5 extended by palpation and visual exploration of Levels 2 and 3 did not reveal other suspicious lymph nodes. The tumor's location was favorable and resection spared the brachial plexus, the accessory nerve, the phrenic nerve, and the thoracic duct. Pathology confirmed radical removal of the 8.1 cm tumor. Other dissected lymph nodes did not show malignancy.

The procedure was successful and uncomplicated. Postoperative pain was minimal, and, after recovery, the patient was pain free. Medical recovery took two days. There was no local recurrence until the time of death two months later.

Comment

Only 30% of all patients presenting with NSCLC are considered for curative treatment, often surgical.[3] The role of surgery for patients with widespread disease is minor and for Stage IV disease, negligible.[4] Chemotherapy and supportive care are now considered the standard of care.[3] Studies considering surgical palliation in advanced NSCLC are rare, and those studying palliative neck surgery in NSCLC even rarer. Metastasectomy in general has been shown to provide a survival benefit, and even long-term survival, for specific patients. This significant improvement has been seen in patients with synchronous solitary (skip) metastasis and a primary tumor suitable for radical therapy. With extended lymph node involvement and multiple site metastatic disease, there has been little to no additional survival benefit after surgery.[4,5]

Metastasectomy for supraclavicular metastasis has not been mentioned in prior studies. Only one study, done in Japan, specifically considered neck surgery in NSCLC for curative purposes. However, patients still had poor prognoses after dissection, with high local recurrence rates; neck dissection was not advised in the management of NSCLC.[6] For palliative purposes, no literature was found on this very specific topic.[1]

Our patient had received initial surgical treatment but required a new treatment strategy after discovery of the additional metastases. Although chemotherapy was indicated, the patient declined any systemic treatment as she felt it would decrease her quality of life; her wishes were respected. Eventually, however, palliation for the supraclavicular lymph node tumor was necessary as it was a significant physical and psychological burden for the patient. The tumor was close to the skin surface and, therefore, noticeable with every neck movement; she was confronted with the disease at every moment of every day. Also, the ulcerating lesion was painful, and the patient needed morphine therapy for pain control. Because further growth of the lymph node metastasis could lead to destruction of surrounding structures, such as the brachial plexus, the phrenic nerve, or the thoracic duct, metastasis-directed therapy was called for.