Mesothelioma Surgery under Cancer Guidance

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Abstract

Malignant Pleural Mesothelioma (MPM), a rare and deadly malignancy, has many different histologic subtypes, including epithelioid, biphasic, and sarcomatoid. The median life expectancy is dismal, only 24 months even in the early stages of the sickness, and it progressively drops as the illness worsens. Data from the United States show that the incidence has been steady in male patients since 1994 and has not changed in female patients for decades, suggesting that this malignancy may have other origins. A long term asbestos exposure is thought to contribute to the condition known as 1 MPM.

Introduction

The rarity of this illness makes it difficult to determine the best course of treatment; current National Comprehensive Cancer Network recommendations [1]. Interdisciplinary treatment, with possible surgical excision and some type of chemotherapy when possible. Uncertainty exists over the best kind of surgery, chemotherapy, radiation, sequencing, and/or mix of modalities. One specific query has been whether surgery is appropriate for all three MPM subtypes. In this issue of CHEST, Mansur et al. examined data from the National Cancer Database from 2004 to 2017 for stages IA to IIIA in an effort to settle the debate over the use of surgery [2]. With the contentious issue of whether surgical resection favours biphasic or sarcomatoid histologic situations, as indicated by the shifting guideline recommendations for and against in recent years, they particularly questioned the role of surgery for histologic subtypes of MPM. The research team concentrated on patients undergoing cancer-specific surgery [3], which comprised both curative and diagnostic, exploratory, and palliative treatments. Surgery was performed either by itself or in conjunction with radiation or chemotherapy. These patients' conditions were compared to those of patients who were undergoing radiation or chemotherapy [4]. In the end, only 7% of MPM patients whose cases were in the National Cancer

Database was appropriate for study. The majority of these cases was either stage IIIB-IV or had inadequate information on the histologic subtype and stage. The analysis was thorough; for each histologic subtype, separate multivariable analyses investigated whether surgery had prognostic value after adjusting for 12 additional variables [5]. This was repeated only counting surgeries with a curative goal and for any surgeries in a landmark cohort of 90 days (i.e., omitting deaths within 90 days). Within each histologic subtype, propensity scoring was done to determine the likelihood that each cohort would have chemotherapy or surgery. This process was repeated using just patients. In both the larger matched cohorts and the subsets without comorbidities, Kaplan-Meier graphs of the matched cohorts consistently showed an advantage for surgery over chemotherapy alone in epithelioid MPM with no difference found in biphasic or sarcomatoid MPM. A significant benefit for any surgery was also shown by the multivariable analysis in epithelioid MPM in the overall cohort, the landmark subgroup, and the full cohort where only curative aim surgery was taken into account. In contrast, neither the total cohort nor the landmark subset of patients with sarcomatoid or biphasic MPM showed any benefit.

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