



LYMPHADENECTOMY DURING RESECTION OF PULMONARY METASTASES FROM SARCOMA

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Surgical resection of pulmonary metastases is considered a standard therapeutic procedure in properly selected cases and is routinely performed in many departments of thoracic surgery. The first resection of a single lung metastasis was discovered during the excision of a chest wall sarcoma in 1882 and in 1965 Thomford was described the principles and methods of pulmonary metastases surgery. Sarcomas represent a rare (1% of all cancers) and heterogeneous group of tumors, arising both from soft tissues and bones. These tumors show a high propensity to metastasize to the lung; about 20% of patients diagnosed with soft-tissue sarcoma and 40% of those with a primary bone sarcoma will develop pulmonary metastases at some point in the course of their disease.

In 1997, the longest series to date of patients with resected pulmonary metastases was published, a total of 5206 patients, where it was observed that the most important prognostic factors were complete resection, number of metastases resected, disease free interval and type of primary tumor. The overall survival was less than 40% at 5 y, 26% at 10 y and 22% at 15y. LN removal during pulmonary metastasectomy is not generally accepted by the European Society of Thoracic Surgeons (ESTS) members. The Spanish national registry on lung metastases of colorectal carcinoma showed that lymph node involvement is a prognostic factor, but only 48% of the groups performed some type of lymphadenectomy. Lymph node (LN) removal during pulmonary metastasectomy is a prerequisite to achieve complete resection or at least collect prognostic information, but is not yet generally accepted. It has been observed that when a systematic lymph node dissection or even sampling is carried out, considerable values of lymph node involvement are found, finding up to more than 40% tumor involvement

The latest studies of the past decade of pulmonary metastases of sarcoma show that the only study in which a systematic lymph node dissection was performed concurrently with the resection of lung metastases identified hilar or mediastinal lymph node involvement in 28% of cases, without a significant impact on survival. Sarcomas are believed to spread primarily through a hematogenous route, thus, unlike in other secondary tumors of the lung, lymph node involvement is rarely seen, except for some histological subtypes as malignant fibrous histiocytoma, rhabdomyosarcomas, synovial sarcomas and epithelioid sarcomas.

Lymphadenectomy in pulmonary Metastasectomy is a crucial prognostic factor depending on a primary tumor.

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