

# COMENTÁRIO EDITORIAL

**Nuno Carvalho Guerra**

Cardiothoracic surgeon  
Associated Editor – Cardiac Surgery  
University Hospital Santa Maria – CHLN, Lisbon  
nmncguerra@gmail.com

## Lung cancer simultaneous to cardiac disease - should we accept lesser treatments?

In this current issue of *Revista Portuguesa de Cirurgia Cardiorádica e Vascular*, *Adrega et al.*<sup>1</sup> offer the readers a paper about an interesting subset of patients - the ones presenting with concomitant cardiac disease and lung cancer.

Lung cancer has long been considered a very serious diagnosis, and rightly so. Even with modern diagnostics, imaging, surgical techniques, chemotherapy and radiotherapy, survival at 5-years is only satisfactory at best (less than 50% in IIB or higher staging). In face of such a disheartening panorama, the presence of severe cardiac disease needing intervention has been considered an even harder challenge - concomitant disease raises anaesthetic, surgical and even risk/benefit questions, because life expectancy with lung cancer is still so short.

Some isolated international experiences have been previously published<sup>1-4</sup> regarding concomitant lung cancer and severe heart disease, including some cases of simultaneous surgical treatment of both diseases. In most, results were satisfactory, with low hospital mortalities<sup>2-4</sup> even when extreme lung procedures like pneumonectomy were undertaken simultaneously with CABG. Still, these patients have been a source of concern for cardiothoracic surgeons, due to the fear of heightened complication rates in patients who frequently, associated with extensive tobacco consumption, have chronic pulmonary obstructive disease and associated peripheral artery disease.

The recent advent and constant improvement of percutaneous techniques for severe heart disease has also changed a bit the management of these patients. Current percutaneous aortic valve implantation has offered these patients and their doctors the possibility of treating e.g. aortic stenosis and, a few days later, undergoing a curative lung procedure, with minimal morbidity.

The same is not true in coronary disease, in which the use of a drug eluting stent would postpone, due to obligatory double anti-platelet therapy, the much needed curative lung surgery, with severe repercussions in the patients chance of cure and life expectancy.

Ideally, these patients should be managed, when possible, in a single surgical act, but this is not always possible or advisable. Staging of the lung cancer is probably the most important clinical aspect to take into account - patients with a severely compromised life expectancy should be treated by percutaneous techniques and then attempt a curative lung resection if indicated (with the exception of coronary artery disease). On the other hand, a patient with a low staging can expect a satisfactory life expectancy after a curative lung resection. Should this patient be offered a percutaneous technique if he is a low risk candidate for aortic valve surgery, just on the account of his lung disease?

*Adrega et al.*<sup>4</sup> present their experience with these patients, and show us that very good results, with minimal morbidity and no mortality, can be achieved. In these cases, the option for open heart surgery has clearly been a good one. Probably, the truth in concomitant disease mirrors the one for isolated disease - for otherwise low risk patients, we should offer them the best possibility for treatment, which in these cases of concomitant disease is minimally invasive lung surgery and open heart surgery. When possible and advisable, simultaneous surgical treatment of both disease is safe and effective, and spares the patients and the health system additional procedures.

*Adrega et al.*<sup>4</sup> have helped to answer a bit more the question of how to manage these patients - in low oncologic staging patients, offering them the best treatment in the most minimally invasive way possible offers very low morbidity and very good event-free survival at medium term.

We will continue to meet these patients in the future, and probably more frequently. We should also continue to offer them the best of Cardiothoracic Surgery - a case by case planning and discussion, as a Team, to offer the patient. The good results of this strategy in these complex patients are patent in *Adrega et al.*'s article.

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