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Commentary: Keep swinging for the fence—some patients will survive

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Li and colleagues¹ report the resection of a single metastatic lesion from malignant pleural mesothelioma (MPM) to the brain. This patient presented with a neurologic emergency; therefore, urgent resection of this lesion was a life-saving procedure that was certainly indicated. As noted by a long, event-free survival after metastasectomy, this patient benefited from the management by their neurosurgical colleagues. In contrast to this patient, the benefit of resection of metastatic disease in the asymptomatic patient is less obvious.

In the United States, about 3000 patients are diagnosed with MPM, and a relatively small percentage undergo cytoreductive surgery.^{2,3} Most patients who experience recurrences have unresectable, metastatic, or locally advanced disease. A few patients will present with 1 or a few lesions amenable to surgical resection. For these patients, resection of the lesion or lesions may be beneficial, but this small group of patients with a rare disease is unlikely to be studied by a randomized trial. However, do we have data that can help guide surgical resection for oligometastatic disease?

Li and colleagues discuss that most reports of metastasectomy for metastatic MPM consists of case reports. As the authors note, Burt and colleagues⁴ found that a longer disease-free interval (DFI) was associated with longer overall survival (OS). However, the study of Burt and colleagues reports the outcomes after chest wall resection, which is not truly a metastatic disease. Ipsilateral thoracic recurrences



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CENTRAL MESSAGE

Metastasectomy for MPM has minimal data. Prognostic factors from other histologies including symptomatic lesions, long DFI, few lesions, and a reasonable performance status can help guide decisions.

are more likely local recurrences. Regardless, the finding that DFI is associated with long OS is consistent with reports of metastasectomy from many histologies. Rigorous data for metastasectomy are usually lacking; however, favorable prognostic factors reported in multiple histologies can help guide clinical decisions. Those favorable factors include a single or limited metastatic lesions, long DFI, good performance status, and lack of good systemic options. This patient had all these favorable prognostic factors in addition to acute symptoms.

All of us who manage patients with malignant disease are often asked, “How long do I have to live?” For patients with epithelioid histology who undergo multimodality therapy with cytoreductive surgery, the median OS in our center is 27 months. Therefore, if we tell 100 patients that they will survive 27 months, we will be correct in exactly one (the median) of 100 patients. About 50 patients will not live 27 months and the other 50 will live longer than 27 months. The patients with a long DFI have “beat the median” and create the “tail of the curve”; therefore, the survival statistics from the diagnosis and initial treatment do not help clinical decisions for this group of patients. Even though MPM is a highly aggressive disease, some patients experience long-term survival and likely have a less-aggressive biology than most patients. For these patients, consideration of metastasectomy is reasonable, especially with long DFI, few lesions, and a reasonable

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performance status. Some patients will continue to “beat the curve” and, hopefully, we can help them live longer even in the absence of strong data.

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