Editorial Commentary

Indolent stage IVA thymic malignancies managed with multimodality treatments

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I would like to congratulate on Choe and colleagues for this excellent work and appreciate the privilege to write an invited Editorial on their recent article published in *the Journal of Thoracic and Cardiovascular Surgery* (1). In summary, they presented outcomes of patients undergoing multimodality treatments including surgery for stage IVA thymic epithelial tumors (TETs), on the basis of their prospectively maintained database. Their major finding was that prolonged survival can be achieved in select patients undergoing multimodality treatments for thymic malignancies metastasizing to the pleura or pericardium.

TETs are the most frequent tumors of the anterior mediastinum in adults and include thymoma, thymic carcinoma, and thymic neuroendorine carcinoma, each of which has multiple subtypes. Among them, stage IV TETs are challenging to manage. There is a paucity of published data upon the management of stage IV TETs and an absence of high quality evidence due to the small sizes of relevant published cohorts.

The guidelines from National Comprehensive Cancer Network, European Society of Medical Oncology, and Japan Lung Cancer Society provided recommendations on the basis of stages of TETs (2-4). The staging system is in transition from Masaoka staging to TNM staging (the American Joint Committee on Cancer 8th edition), on the basis of which stage IVA diseases include pleural and/or pericardial disseminations and/or anterior lymph node metastasis, whereas stage IVB diseases include distant metastasis and/or deep intrathoracic or cervical lymph node metastasis. According to those guidelines, in stage IVA diseases, surgery may have a role following induction chemotherapy or chemoradiotherapy, while radiotherapy may have definitive therapy concurrently with chemotherapy or have an adjuvant role following surgery (5). In stage IVB diseases, definitive chemotherapy should be given, whereas surgery or radiotherapy does not have a primary role, but may play a role as debulking or salvage. The bottom line is that stage IV TETs require multimodality managements including systemic therapy (chemotherapy). The role of local therapy, such as surgery and radiotherapy, is more limited and should be carefully considered.

Specific contributions by Choe and colleagues to the literature are as follows. Highly selected patients can tolerate multimodality treatments including surgery for stage IVA TETs. There is a subgroup of patients with stage IVA thymic carcinoma who would benefit from surgical managements, although the role of debulking surgery has been undetermined in patients with stage IVA thymic carcinoma (6). And even patients with stage IVB diseases may be indicated for debulking surgery in the setting of multimodality managements, although more database studies would be required to elucidate the role of surgery in stage IVB thymic carcinoma. In addition, details on treatments were described in each patient, which have been often omitted in previous large database studies.

In summary, the recent contribution by Choe and colleagues is seminal work that reminds us of the importance of surgery in multimodality treatments.

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