LETTER

Malignant pleural effusion survival controlled by lent and promise scores

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ABSTRACT

One disease, known as Malignant Pleural Effusion (MPE), is present in 15% of cancer patients. Finding the right treatment is crucial given the short overall survival rate. It should be determined whether cases require a more vigorous course of treatment in addition to palliating secondary symptoms brought on by MPE. The aim of the study was to assess how well lent and clinical promise scores predicted survival in MPE patients.

Keywords: *Malignant Pleural Effusion*

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Cancer patients approximately 15% will experience Malignant Pleural Effusion (MPE), which frequently indicates metastatic illness. Malignant cells found in the pleura and/or pleural fluid are used to diagnose it. Although it is most frequently seen in lung cancer, it can also arise from breast, lymphoma, gynecological, and malignant mesothelioma. In particular, MPE is detectable at the time of diagnosis in 15% of patients with lung cancer. As a sign of a poor prognosis, MPE may also be present at the time a malignant disease is diagnosed or may develop throughout the follow-up procedure. Low pH in pleural fluid, higher neutrophil/lymphocyte ratios, High Lactate Dehydrogenase (LDH) values, and poor performance score Eastern Cooperative Oncology Group (ECOG) are all warning signs. Finding the right treatment plan for MPE patients is crucial due to the poor overall survival rate. It should be determined whether cases require a more vigorous course of treatment in addition to palliating secondary symptoms brought on by MPE. The right course of treatment should be chosen based on the patients' anticipated survival time. It was shown that employing characteristics that predict survival allows for the planning of treatments that are more cost-effective for patients with MPE. It has recently been proposed that studies on prognostic markers that would predict survival in MPE patients employ scoring systems rather than a single marker. The database built using SPSS version 18 contained the information gathered during the study. The SPSS and MedCalc package packages were used to statistically analyze the data. Frequencies and percentages are used to present categorical variables. The diagnostic marker values were determined and the variables impacting survival were prepared in cross-tables. The log-rank test was performed to compare intergroup survival rates, and the Kaplan-Meier method was employed for the survival analysis.

The Wald value Cox regression analysis with a backward step approach was used to examine the components that contributed to mortality. The first-type error share was examined bilaterally and determined to be 0.05 in all experiments.

Poor performance scores and the progression of the lent risk group from the low to medium/high-risk group or the promise category from A to B, A to C, or A to D resulted in a statistically significant increase in mortality risk in the group of patients with MPE, according to a single-variable analysis. According to the findings of the multivariate analysis, individuals with poor performance scores and those in promise categories B, C, and D have significantly higher mortality risks at 1 month, 3 months, and 12 months. Only 12 months of survival in the high lent risk group revealed an elevated mortality-risk.

There may be a few explanations for why the lent score in our study accurately predicted mortality risk after just 12 months of survival. Sensitivity to chemotherapy is one of the most critical elements impacting survival when it is taken into account that the typical survival time after a diagnosis of MPE is 3 months to 12 months. Different histological forms of lung cancer may respond to treatment differently even when taken separately. Additionally, better palliative care options for cancer patients in the final stages of their illness improve patient comfort and length of survival. Because of this, it's possible that the lent score's best window to predict survival was found to be 12 months. When the lent score is taken into account, this evaluation is crucial because it demonstrates that the lent score was improperly applied. After all, other cancer types (such as hormone receptor-positive breast cancer and hematological cancer) can respond well to chemotherapy and the lent score was more of a scoring system that could indicate prognosis in MPE due to lung cancer.

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Since malignant mesothelioma was diagnosed in 9.5% of the patients in our study and lung cancer affected 79.9% of them, it can be argued that our patient group's response rates to chemotherapy were low. This makes our findings more trustworthy. There are some limitations in our study, even though the number of patients was adequate and comparable to other studies in the literature.

Our analysis only included patients who had a confirmed diagnosis of MPE; cases with Para malignant effusion or suspected MPE were not included. One of the shortcomings of our study was the failure to conduct separate survival analyses for various oncological diagnoses related to primary tumors and the failure to take into account how treatment variations, even within the same cancer kinds, affected outcomes.