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The letter by Migliore et al. [1] describes very well the points of discussion concerning the resection of patients with lung metastases from colorectal cancers. In fact, even though the commonfeeling among oncologists is that a patient should be resected whenever possible, currently no data exist to definitively demonstrate whether the better outcome of resected patients is the result of surgery or patient selection. Even our findings were not able to provide the last word to this debate [2].
Despite this limitation, we decided to analyze our data from an oncological point of view, discussing several aspects of the problem. First, we highlighted some aspects that are not perfectly clear in the oncological community, such as the incidence of lung metastases in advanced colorectal cancer, which occur in nearly one third of these patients at the time of first metastasis appearance. Second, we demonstrated that a higher proportion of patients were resected in centers where a thoracic surgeon is present in the multidisciplinary team, underscoring the importance of collaboration beyond abdominal surgeons. Third, we reported long-term survivors only among resected patients. In addition, we described the characteristics of patients undergoing surgery, confirming that surgeons are driven by some selection criteria in their decision-making process. Even though they were well described, these criteria were questioned by some authors, as discussed in the review by Pfannschmidt et al. [3]. For example, the number of lung metastases were reported to be a prognostic factor by two authors, although it was reported to have no influence in 12 other studies. This discrepancy is probablydueto heterogeneity and the small number of patients in the different studies, signifying the large number of variables that can influence patient outcome.
To add further confusion to a complicated debate, few papers took into account the role of neoadjuvant or adjuvant chemotherapy—the latter of which is beneficial to patients with stage III disease because it reduces the number of patients who relapse after surgery [4]. Oncologists may not be fully aware that lung metastases can be well-controlled or even cured if well-managed, as described in our article. To better describe the natural history of lung metastases from colorectal cancer, define variables involved in determining patient outcome, and finally solve this debate, we believe that oncologists and surgeons should work together and share their experiences. In this respect, the PulMiCC (Pulmonary Metastasectomy in Colorectal Cancer) [5] trial is very welcome because it will surely add new evidence to the debate.
However, we would like to further propose the creation of an online database in which data on patients with lung metastases, resected or not, could be input by several oncological and surgical units worldwide (following the example of liver surgeons participating in the LiverMetSurvey Project [6]) to permit more accurate observational description of this not negligible proportion of patients.

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