

The authors reported no conflicts of interest.

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REPLY: THE IMPORTANCE OF APPROPRIATE SELECTION FOR SEGMENTECTOMY



Reply to the Editor:

We appreciate the response to our commentary by Liu and colleagues¹ regarding the study by Razi and colleagues² evaluating segmentectomy versus lobectomy for cT1 N0 M0 non-small cell lung cancer who were discovered to have “unsuspected” pathologic N1 or N2 disease. We largely agree with the key points raised by Liu and colleagues. Appropriate selection of patients for segmentectomy is critical. In general, segmentectomy can be a reasonable choice for small, peripheral tumors that are ≤ 2 cm in diameter when a segmental margin that is greater than or equal to the tumor diameter is achievable, particularly in patients with advanced age, who are frailer and have reduced cardiopulmonary reserve. There are 2 ongoing randomized controlled trials—the results of which are eagerly anticipated—designed to further improve our understanding of patient selection for limited resection for cT1a (peripheral tumors < 2 cm) N0 M0 non-small cell lung cancer: CALGB 140503³ and JCOG0802/WJOG4607L.⁴

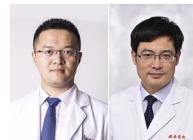
In the era of lung cancer screening and increased identification of small, peripheral tumors, the uncommon scenario of unsuspected N1 and N2 disease during a segmentectomy will likely become more frequent. It will be important to continue evaluating questions regarding the extent of parenchymal resection in the setting of N1 and unsuspected N2 disease in well-designed multicenter studies that have granular data that include details about N1 and N2 lymph nodes and that have data regarding pulmonary function.

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ROBOTIC SEGMENTECTOMY: WE ARE STILL ON THE WAY



To the Editor:

In their Commentary, Song and Flores¹ propose several thoughtful questions and describe certain limitations of robotic segmentectomy. We cannot agree with them more. However, we are still willing to clarify the question inherent to their Commentary.

Our study² indicated that robot-assisted thoracic surgery (RATS) demonstrated improved N1 node retrieval as a potential benefit; however, nodal upstaging did not achieve a significant difference between the 2 groups. We only observed 2 cT1b N0 adenocarcinomas in the RATS group upstaged to pT1b N2 after propensity score-matched analysis.² The possible reasons for this low rate of nodal upstaging in our study were the careful determination of clinical stage with positron-emission tomography, computed tomography, and other methods as well as strict selection of slowly growing ground glass opacity (GGO) nodules for segmentectomy procedures in both cohorts. It seems that difference in nodal upstaging between these 2 techniques is still controversial. Wilson and colleagues³ reported that the rate of nodal upstaging for robotic anatomical resection, including lobectomy and segmentectomy, appeared to be superior to video-assisted thoracoscopic surgery (VATS) and similar to thoracotomy for stage I non-small cell lung cancer. Further, a recent