REPLY: ROBOTIC-ASSISTED SEGMENTECTOMY: DOING IT SIMPLY BECAUSE WE CAN?

Reply to the Editor:

In their response[1] to the recent commentary by Kim and Bharat,[2] Zhang and Li address some limitations of their recent retrospective study[3] comparing outcomes of video-assisted (VATS) and robotic-assisted (RATS) thoracoscopic segmentectomy.

We agree with Kim and Bharat that generalizability of the data is limited when considering the varying experience and clinical volume at different hospital systems. Zhang and Li pose that potential variability during pathologic processing at the different hospitals in their study was minimized by the identification of nodes by the surgeons in the operating room. On the contrary, we contend that nonblinded marking of the specimen by the surgeon investigators has the potential to introduce significant bias.

The authors view the VATS and RATS techniques as complementary and state that the platform should be determined by surgeon preference and available resources. While this is generally a valid approach to all surgical planning, they further claim that the learning curves are similar, citing their previous study, which identified 40 cases as the minimum number required to achieve technical competency in robotic segmentectomy.[4] In that study, however, each surgeon was required to have previous experience with at least 500 VATS and 20 RATS lobectomies, and it was acknowledged that a longer learning curve was likely for those without a similar background.

Why pursue a procedure that is more expensive, has a learning curve built on previous VATS experience, and lacks proven clinical benefits? Just because we can do a procedure doesn't mean we should.

Kimberly J. Song, MD
Raja M. Flores, MD
Department of Thoracic Surgery
Icahn School of Medicine at Mount Sinai
New York, NY

References

1. Zhang Y, Li H. Robotic or thoracoscopic segmentectomy: being the complement of each other. *J Thorac Cardiovasc Surg*. 2020;160:e175.
2. Kim SS, Bharat A. Commentary: Video-assisted thoracoscopic surgery versus robotic assisted surgery: are we asking the right question? *J Thorac Cardiovasc Surg*. February 7, 2020 [Epub ahead of print].
3. Zhang Y, Chen C, Hu J, Han Y, Huang M, Xiang J, et al. Early outcomes of robotic versus thoracoscopic segmentectomy for early-stage lung cancer: a multi-institutional propensity score-matched analysis. *J Thorac Cardiovasc Surg*. January 25, 2020 [Epub ahead of print].
4. Zhang Y, Liu S, Han Y, Xiang J, Cerfolio RJ, Li H. Robotic anatomical segmentectomy: an analysis of the learning curve. *Ann Thorac Surg*. 2019;107:1515-22.

https://doi.org/10.1016/j.jtcvs.2020.04.162

THE "MULTISPECIALTY CLINIC": TOWARD A NEW PARADIGM IN THORACIC ONCOLOGY?

To the Editor:

We read with interest the article "Multidisciplinary Selection of Pulmonary Nodules for Surgical Resection: Diagnostic Results and Long-term Outcomes" by Madariaga and colleagues.[1] We want to comment from a somewhat philosophical point of view. We began a similar multispecialty pulmonary nodule clinic in early 2013 and briefly reported our preliminary experience in 2015.[2] At the root of this initiative was an intuition that the nature of pulmonary oncology was changing. We were seeing more and more frail patients with multiple health issues. We were also seeing more and more patients with multiple lung nodules, either synchronous or metachronous. At the same time, therapeutic options were evolving rapidly. Minimally invasive thoracic surgery had gradually become the standard of care. Stereotactic radiotherapy was allowing for the eradication of small tumors with minimal patient discomfort and minimal morbidity. Percutaneous ablation was being refined and its role in lung cancer reevaluated. Because each of these modalities had a unique and evolving profile in terms of patient safety and oncologic outcomes, the requirement for active multispecialty collaboration in any decision-making process seemed only a logical consequence: thus, our preference for the term "multispecialty." As Madariaga and colleagues[1] have rightly pointed out, the requirement for complex decision making will only become more acute with the gradual implementation of lung cancer screening programs.

Because of its nature as a large, diverse group operating within a specified clinical and administrative framework, the traditional "tumor board" seemed to us ill equipped to deal with some of these complex issues because tumor board discussions simply cannot account for highly individual considerations and cannot appreciate the fine details of the applications and implications of highly specialized treatment modalities, let alone allow for patient participation in complex decisions.