

The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.



REPLY: ROBOTIC-ASSISTED SEGMENTECTOMY: DOING IT SIMPLY BECAUSE WE CAN?
Reply to the Editor:



In their response¹ to the recent commentary by Kim and Bharat,² Zhang and Li address some limitations of their recent retrospective study³ 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 colleagues¹ 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.

The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Unfortunately, although it continues to function in an “ad hoc” fashion, our clinic never really got off the ground. The reasons are important to consider here. Although there were some logistical challenges, the main obstacle by far was our failure to get hospital leadership and fellow practitioners to “buy into” our vision. The lack of easily quantifiable benefits made it difficult to make an effective case to hospital leadership in a cost- and resource-conscious environment. And despite our best efforts to include all relevant stakeholders as active partners, we failed at defining the clinic as an additional specialized resource rather than a “competitor” that might encroach upon the professional autonomy of referring physicians or the “authority” of the tumor board. In light of such possible challenges, Madariaga and colleagues’ efforts¹ are all the more commendable and all the more important.

We remain more convinced than ever that a dedicated multispecialty clinic is an essential resource within the context of an increasingly complex oncologic reality. It will enable the individualization of care, active participation of patients in decision-making, and optimization of resources. We wholeheartedly encourage other programs to take up this “radical” concept. By keeping this conversation going, we may ultimately succeed in implementing multispecialty collaboration as a new paradigm in thoracic oncology.

George Rakovich, MD^a

Alexis Bujold, MD^b

Section for Thoracic Surgery

Departments of ^aSurgery

^bRadiation Oncology

Hôpital Maisonneuve-Rosemont

University of Montreal School of Medicine

Montreal, Quebec, Canada

References

1. Madariaga ML, Lennes IT, Best T, Shepard JO, Fintelmann FJ, Mathisen DJ, et al; MGH Pulmonary Nodule Clinic Collaborative. Multidisciplinary selection of pulmonary nodules for surgical resection: diagnostic results and long-term outcomes. *J Thorac Cardiovasc Surg.* 2020;159:1558-66.
2. Vallée CA, Bujold A, Carignan S, Rakovich G. A breath of fresh air 2015/conference abstracts. A multi-specialty thoracic oncology clinic for individualizing the care of high risk patients. *Can Respir J.* 2015;22(Suppl A):15.

<https://doi.org/10.1016/j.jtcvs.2020.04.176>



REPLY: PROVIDING AN HONEST PERSPECTIVE ON CREATING A NEW TREATMENT MODEL

Reply to the Editor:

In their correspondence, Rakovich and Bujold highlight their experience with developing a multidisciplinary or “multispecialty” pulmonary nodule clinic. Specifically, they discuss some of the more practical challenges they faced along the way. Among these challenges included obtaining leadership “buy-in” and garnering the trust and support from potential referring partners. Sharing both the successes and the challenges of launching a new treatment paradigm with the greater thoracic community should be encouraged. The comments by Rakovich and Bujold are relevant, helpful, and appreciated.

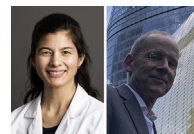
Melanie P. Subramanian, MD, MPH

Division of Cardiothoracic Surgery

Washington University School of Medicine

St Louis, Mo

<https://doi.org/10.1016/j.jtcvs.2020.05.062>



REPLY FROM AUTHORS: THE MANY BENEFITS OF A MULTIDISCIPLINARY EVALUATION OF LUNG NODULES

Reply to the Editor:

There are various reasons to conduct the multidisciplinary evaluation of lung nodules, and no single model, however successful at one time in one institution, may be expected to succeed universally. In their article, Drs Rakovich and Bujold share their vision of a clinic motivated by the increasing age and frailty of patients.¹ We regard their idea as entirely sound. Our clinic originated from the desire to connect radiographic and individual patient risk factors in a conference immediately before those patients whose radiographs were reviewed are provided with an opinion. The concept of a conference was not hurt by the availability of lunch and banter at noon every Friday. What helped in starting our clinic was the willingness of multiple specialists to