


Key Words: non–small cell lung cancer, neoadjuvant therapy, surgery, pulmonary artery, nodal disease

Discussion

Presenter: Dr Hope Feldman

Unidentified speaker 1. Discussion will be opened by Lana Schumacher from the Mass General Hospital.

Dr Lana Schumacher (Boston, Mass). Hi. Excellent presentation and thank you for your work. Thank you to the organization and the WTS for allowing me to discuss this, and I appreciate the fact that you did give me the paper to review. And I think you did an excellent presentation. And this is a novel study looking at—there are plenty of literature that we’ve seen with nodal complications leading to bleeding and how to deal with them and whatnot and what to predict. But this is a really nice study where you actually measured measurements of neoadjuvant therapy and the reduction in node response and how this can lead to increased adherence. I know there was a paper that was recently presented or published by [inaudible] that just looked at factors that contribute to nodal adherence but not in this degree, where you’re actually looking at what did the neoadjuvant treatment regimen do to your nodes and how is this going to affect you? So, my first question is how do you think your patients can undergo these more challenging dissections? Is it going to change the paradigm in how the surgeons look at this?

Dr Schumacher. Excellent. My last question, are you going to also look at this study with [newer?] agents? I know you had mentioned that, and hopefully, you will continue this.

Dr Feldman. Yes. Dr Antonoff is definitely continuing this work in the setting of targeted therapies.

Dr Schumacher. Great. Excellent job.

Dr Feldman. Thank you.

Dr Schumacher. Thank you.

Dr Robert Cerfolio. You have such a unique opportunity to teach so many people in this room. And you have a slide...
that says, “Nodal adherence to artery forces change in approach to vasculature.” No, it doesn’t. It’s changing approach to the bronchus. Cut the bronchus. If you just cut the bronchus, you don’t have to get around the artery. So, I think that’s the big trick. That’s why we do—and I know you’re not going to believe me, but enough people in the room have seen this—100% of these robotically. Every single one is done robotically, with a conversion rate of less than 2%. And it is better for the patient. So, it’s good to say outcomes are the same, but they’re not. You’d much rather have those minimally invasive than an open. And we do them together as a team. But I think the unique opportunity here is to teach people when you can’t get around an artery, instead of digging around to get—yes, you get proximal control, but just take a bipolar, if you use a robot. You can lower the FiO₂ in the inspired air from the anesthesiologist, but you don’t have to. Airway fires don’t happen. But if you’re worried about it, do it. And just cut the B2 or the B3 or the B1 bronchus. They’re usually left upper lobes, almost all of these. If you cut the B2 and then start bringing it back down even to the B4 or 5, the artery’s just hanging out in the breeze. And then you can go get it.

**Dr Feldman.** I appreciate that comment. I’m a second-year general surgery resident completing two years of research [crosstalk]. [applause]

**Dr Feldman.** So, I’ll use that as a learning opportunity. Thank you.

**Unidentified speaker 1.** Wait. Robert, if you still have the node invading the artery, you’ve got to do the sleeve.

**Dr Cerfolio.** [inaudible].

**Dr Mara Antonoff.** Just to clarify, if you change the order of the steps that you’re doing in the operation, that is technically a change in the approach to the vasculature. You’re not taking the artery at the time when you otherwise might have done it. You’re taking the bronchus first and then approaching the artery from a different angle.

**Dr Feldman.** Thank you.

**Dr Schumacher.** Excellent job. [applause]