Less is More
To the Editor:

We read with great interest the retrospective study by Perez Holguin and colleagues1 reporting that there is no difference in overall survival between sublobar resection and lobectomy in patients with cTis N0 M0 non–small cell lung cancer (NSCLC) with tumors ≤2 cm in the cohort of the National Cancer Database. The study aroused enormous interest and caused a heated discussion: “What are the practical implications of this study?” and, “Might these findings influence clinical practice?” Recently, results of JCOG0802/WJOG4607L showed the benefits of segmentectomy vs lobectomy in the overall survival of patients with small-peripheral NSCLC (tumor diameter ≤2 cm; consolidation-to-tumor ratio >0.5).2 Similarly, results of another phase 3 trial, CALGB140503, suggested that sublobar resection was not inferior to lobectomy for disease-free survival in patients with peripheral NSCLC with tumor size ≤2 cm and pathologically confirmed the node-negative disease in the hilar and mediastinal lymph nodes.3 It is worth noting that the number of patients with carcinoma in situ may be minimal in these 2 trials. The latest results of JCOG1211 showed that segmentectomy should be considered as part of standard treatment for patients with predominantly ground-glass opacity NSCLC with tumor size ≤3 cm in diameter.4 Thus, we need to rethink whether or not a patient with carcinoma in situ should undergo the procedure. Previous studies have reported that tumors ≤2 cm with a consolidation/tumor ratio ≤0.25 were considered radiologically noninvasive cancers with a low risk of metastasis.5 Thus, although these tumours can be cured by lobectomy or sublobar resection, surgical resection for some of these lesions that are stable over a long period may not improve the prognosis. Lung resection leads to a loss of lung capacity, even in partial resections, and is associated with a risk of adverse events. Thus, observation can potentially avoid surgical resection, which may be the least-invasive approach for patients.

Therefore, we would appreciate it if the authors could answer the following questions so that we could better understand this question:

a. Although the authors mentioned that TNM status was determined based on editions 6 and 7 in this study, how to define “cTis” is still very important. According to the eighth edition TNM staging, “cTis” is defined as pure ground-glass lesions without solid components. However, surgery is unnecessary for such patients with pure ground-glass lesions.

b. If the “cTis” is defined as pure ground-glass lesions, or at least some patients have pure ground-glass lesions, how are these lesions defined in imaging? Were the primary lesions evaluated using thin-section computed tomography images?

c. What is the lung cancer-specific mortality of the 2 groups? Lung cancer-specific mortality is among the most important indicators for better comparison. Given the opportunity, we are more than willing to share our data and outcomes of patients with c-stage IA NSCLC presenting as ground-glass opacity. Let’s agree to disagree and base our arguments on further convincing studies.

References

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LETTER TO THE EDITOR

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