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See related article on page 433.

The report by Yoshimasu and associates¹ is an analysis of 58 patients, selected from a pool of 308, who underwent surgical intervention for primary lung cancer at their university. As an alternative to complete mediastinal lymphadenectomy at the time of pulmonary resection, they sampled one lymph node from each of three stations. They justify this partial dissection by citing a previous study that showed this method to be 94.5% accurate. The authors conclude that this limited dissection of the three stations “seems more practical and convenient” than sentinel lymph node mapping. Additionally, they conclude their findings validate limited mediastinal lymph node dissection.

Because the American College of Surgeons Oncology Group (ACOSOG) Z0030 study, a randomized trial that looked at more than 1000 patients and compared lymph node sampling with lymph node dissection, found no increase in morbidity or mortality from lymph node dissection, there seems little benefit to limiting a mediastinal lymph node dissection.² The status of thoracic lymph nodes is the main determinant of outcome for a patient with a resectable lung cancer. Without lymph node involvement, cure rates of 70% to 90% can be expected. With lymph node involvement limited to the N1 lymph nodes, a 40% to 50% 5-year survival can be expected. Unfortunately, N2 lymph node involvement portends a poor 5-year survival. Thus accurate mediastinal nodal staging is critical to predicting long-term survival. Furthermore, with the recent finding that patients with N1 or N2 involvement are helped by postoperative chemotherapy, incomplete or inaccurate nodal staging could potentially prevent some patients from receiving beneficial postoperative chemotherapy.³

Removing a few lymph nodes from selected nodal stations on the basis of what lobe the cancer is in adds confusion and complicates an operation. Because there is not an increased risk of complications from a mediastinal nodal dissection, all of the mediastinal lymph nodes should be removed.

As thoracic surgeons specializing in lung cancer treatment, we should encourage complete lymph node resection during pulmonary resections for lung cancer. The disturbing report by Little⁴ presented at the recent Society of Thoracic Surgeons meeting in January of 2005 highlights the need for change. He reviewed the pattern of surgical care in more than 11,000 patients with lung cancer. Analysis revealed that only 34% of patients had any lymph node biopsy. That is not a typographical error. No lymph nodes were sampled in 66% of patients undergoing pulmonary resection for lung cancer! Before we try to decide whether we should sample three stations, do a sentinel lymph node dissection, or do some other limited resection, we should encourage surgeons to be sure that all patients surgically treated for lung cancer have at least some lymph nodes examined. Whether a complete mediastinal lymphadenectomy will improve long-term survival awaits the result of the ACOSOG multicenter trial. This will likely take 4 to 5 years, while follow-up

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matures. In the meantime, patients deserve to have lymph nodes removed to obtain an accurate diagnosis and potentially higher cure rates.

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