AB024. LA09. What extent of node sampling or dissection is appropriate?

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Abstract: ITMIG proposed a recommendation for lymph node dissection (LND) in thymic malignancies in 2011. ITMIG recommended removal of any suspicious nodes, removal of adjacent nodes and anterior mediastinal nodes in stage I and II thymoma, systematic anterior mediastinal node dissection and systematic sampling of appropriate intrathoracic nodes in stage III thymomas and at least a systematic sampling of anterior mediastinal, intrathoracic, supraclavicular, and lower cervical nodes for thymic carcinomas (if the diagnosis is suspected or known). In the meantime, new ITMIG lymph node map and new IASLC/ITMIG stage classification system have replaced the former standards and more knowledges about the pattern of nodal metastasis in thymic malignancies have been accumulate. Our group reported two studies about the extent of LND in terms of number of nodes and nodal station in thymic malignancies. The study about LND in thymic carcinoma suggested more than 10 nodes should be evaluated to predict prognosis accurately in thymic carcinoma. The second study showed histologic subtype and T stage were predictive factors for the nodal metastasis in thymic malignancies. Rate of nodal metastasis in T2/3 tumors was 37.5% whereas only 1% of T1 tumors had nodal metastasis. Nodal metastasis rate was 25% in thymic carcinoma and 5.1% in thymoma. No nodal metastasis was documented in type A/AB/B1 thymomas. An important finding of that study was frequent metastasis to the right paratracheal lymph nodes group. Six out of seven pN2 patients had metastases at right paratracheal lymph nodes. Based on these findings, we proposed a modified recommendation for LND in thymic malignancies and put emphasis on the dissection of right paratracheal lymph node group.

Keywords: Thymic neoplasm; thymectomy; lymph node dissection

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