Letter to the Editor

Response to: intrapulmonary lymph node retrieval

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To the editor,

The heterogenous non-small cell lung cancer (NSCLC) patient population harboring N1 metastatic disease provides both diagnostic and treatment challenges. The wide range of 5-year overall survival (OS) for this diverse group, from 27-67%, clearly illustrates the need for better prognostic, diagnostic and/or treatment modalities (1). Successful nodal staging is a variable greatly influenced by clinician, surgeon and pathologist to identify, resect and interpret. How we achieve this is evolving. Metastasis to mediastinal lymph nodes (LNs), N2 or N3, clearly impacts candidacy for curative intent resections. It is, however, involvement of N1 nodes and their impact in clinically resectable disease that shapes our current discussion.

Recently, Ramirez *et al*. demonstrated improvement in nodal sampling of N1 nodes, identifying an additional 514 LNs in 374 patients, utilizing a more aggressive intrapulmonary staging technique following traditional pathologic staging. Their article "Incomplete Intrapulmonary Lymph Node Retrieval After Routine Pathologic Examination of Resected Lung Cancer" also demonstrated upstaging in 8 of 73 patients based on this technique (2). Data suggests that a greater number of N1 positive nodes impacts survival (3). Although our staging system is not based on quantity, rather presence of metastasis within a LN station, a growing body of literature is examining the impact of the number of LN metastasis (4).

Further studies to evaluate the impact of this technique on patient outcomes are needed. The authors comment on an upcoming study designed to address the upstaging rate and relapse free survival achieved through more thorough intrapulmonary dissection of N1 nodes, citing a recently published case control study where improved mediastinal (N2 and N3) nodal staging utilizing their surgical collection kit was obtained (5).

The enthusiasm of promising data without known clinical benefit must be tempered. Unlike colon cancer where less than 12 lymph nodes obtained for stage II disease clearly impacts outcomes and prompts a discussion regarding adjuvant chemotherapy, we have not reached this milestone yet in lung cancer evaluations. Unlike mediastinal lymph node sampling, where the trend toward aggressive sampling is building data on the impact of missed mediastinal nodes, we have not demonstrated as clear an association with N1 disease (6). Without a doubt the author's continued investigation into the impact of N1 nodal dissection will shape our future understanding of this heterogenous group of patients and foster the integration of the growing body of N1 data into effective clinical choices. However, universal adoption of this technique, outside of the research setting, should be examined once this data is presented and matured.

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