

Supplementary

Appendix 1 Expert panel list

No.	Full name	Affiliation	City	Country
1	Que Kim Do	Thong Nhat Hospital; Pham Ngoc Thach University of Medicine	Ho Chi Minh City	Vietnam
2	Dung Xuan Pham	Ho Chi Minh City Cancer Society	Ho Chi Minh City	Vietnam
3	Thanh Ngoc Le	Viet Nam Association of Cardiovascular and Thoracic Surgery	Hanoi	Vietnam
4	Dung Thi Ngoc Nguyen	Ho Chi Minh City Medical Association	Ho Chi Minh City	Vietnam
5	Huu Cong Nguyen	E Hospital	Hanoi	Vietnam
6	Luong Van Dinh	National Lung Hospital	Hanoi	Vietnam
7	Hoa Thi Thai Nguyen	Department of Medical Oncology, National Cancer Hospital	Hanoi	Vietnam
8	Nguyen Hoang Binh	Department of Thoracic Surgery, Cho Ray Hospital	Ho Chi Minh City	Vietnam
9	Khoi Tuan Nguyen	Thoracic and Gynecologic Medical Oncology Department, Ho Chi Minh City Oncology Hospital	Ho Chi Minh City	Vietnam
10	Trung Quoc Lam	Department of Chemotherapy, University Medical Center Ho Chi Minh City	Ho Chi Minh City	Vietnam
11	Dung Tuan Trinh	Viet Nam Society of Pathology and Cytology	Hanoi	Vietnam
12	Dung Thanh Le	Department of Radiology, Viet Duc University Hospital	Hanoi	Vietnam
13	Anh Tuan Le	Cancer Center, Cho Ray Hospital	Ho Chi Minh City	Vietnam
14	Ha Thu Le	Department of Lung-Breast Medical Oncology, Hanoi Oncology Hospital	Hanoi	Vietnam
15	Lu Huu Pham	Department of Cardiovascular and Thoracic Surgery, Viet Duc University Hospital; Hanoi Medical University	Hanoi	Vietnam
16	Kiem Khac Nguyen	Department of Thoracic Surgery, National Cancer Hospital	Hanoi	Vietnam
17	Thiet Thanh Truong	Department of Thoracic Surgery, Pham Ngoc Thach Hospital	Ho Chi Minh City	Vietnam
18	Lanh Si Nguyen	Department of Pathology, Viet Duc University Hospital; Hanoi Medical University	Hanoi	Vietnam

No.	Full name	Affiliation	City	Country
19	Khanh Gia Ngo	Department of Thoracic and Cardiovascular Surgery, Bach Mai Hospital	Hanoi	Vietnam
20	Hai Vi Ngo	Department of Thoracic Surgery, 108 Military Central Hospital	Hanoi	Vietnam
21	Hai Minh Nguyen	Department of Pulmonology, 108 Military Central Hospital	Hanoi	Vietnam
22	Tuan Quoc Le	Department of Oncology, Da Nang Hospital	Da Nang	Vietnam
23	Tu Anh Thai	Pathology Department, Ho Chi Minh City Oncology Hospital	Ho Chi Minh City	Vietnam
24	Viet Nhu Hung Tran	Department of Thoracic-Vascular Surgery, Gia Dinh People's Hospital	Ho Chi Minh City	Vietnam
25	Minh Duc Nhat Pham	Hepatobiliary and Thoracic Surgery Department, Ho Chi Minh City Oncology Hospital	Ho Chi Minh City	Vietnam
26	Kha Nguyen Dang	Department of General Oncology, Da Nang Oncology Hospital	Da Nang	Vietnam
27	Long Phi Le	Department of Thoracic-Vascular, University Medical Center Ho Chi Minh City	Ho Chi Minh City	Vietnam
28	Nguyen Vo Cong Do	Department of Radiology, Thong Nhat Hospital	Ho Chi Minh City	Vietnam
29	Hoang Manh Tran	Department of Oncology, Thong Nhat Hospital	Ho Chi Minh City	Vietnam
30	Hoang The Ngo	Department of Pulmonology, Thong Nhat Hospital	Ho Chi Minh City	Vietnam
31	Tam Dac Nhan Nguyen	Department of Oncology, Thong Nhat Hospital	Ho Chi Minh City	Vietnam
32	Mot Van Muoi Duong	Department of Cardiovascular, Thoracic and Vascular Surgery, People's Hospital 115	Ho Chi Minh City	Vietnam

Appendix 2 Baseline practice survey results

Characteristics		Result
Respondent specialty	Thoracic surgery	27/35 (77.1%)
	Medical oncology	4/35 (11.4%)
	Respiratory medicine	2/35 (5.7%)
	Diagnostic imaging	1/35 (2.9%)
	Pathology	1/35 (2.9%)
Institutional surgical volume	Monthly number of resected NSCLC cases	Approximately 1-2 to 120 cases per month
Selected preoperative practices*	Chest CT used in more than 90% of patients	76% of respondents
	FDG-PET/CT used in more than 90% of patients	0% of respondents
	EGFR testing performed in more than 90% of patients	30% of respondents
	ALK testing performed in more than 90% of patients	14% of respondents
	PD-L1 testing performed in more than 90% of patients	24% of respondents
Routine MDT practice	Yes	28/35 (80.0%)
	No	7/35 (20.0%)

MDT timing	Before surgery	20/35 (57.1%)
	Before and after surgery	13/35 (37.1%)
	After surgery only	2/35 (5.7%)
Post-neoadjuvant pathologic assessment	Routine pCR/MPR assessment	11/35 (31.4%)
	pCR/MPR assessment in selected patients	14/35 (40.0%)
	No pCR/MPR assessment	10/35 (28.6%)
Postoperative MRD assessment	Routine MRD assessment	9/35 (25.7%)
	MRD assessment in selected patients	16/35 (45.7%)
	No MRD assessment	10/35 (28.6%)

* Each preoperative investigation or biomarker test was assessed as a separate survey item; therefore, percentages across these items are not mutually exclusive and should not be summed to 100%. ALK, anaplastic lymphoma kinase; CT, computed tomography; EGFR, epidermal growth factor receptor; MDT, multidisciplinary team; MPR, major pathologic response; MRD, minimal residual disease; NSCLC, non-small cell lung cancer; pCR, pathologic complete response; PD-L1, programmed death-ligand 1.

Appendix 3 Final consensus statements, recommendation classes, and original voting agreement percentages

Domain	Statement No.	Final statement	Class of recommendation	Original voting agreement
Part 1: Consensus on preoperative diagnosis and staging				
	1	NSCLC should be anatomically staged according to the AJCC/UICC TNM 9th edition. However, eligibility for perioperative or adjuvant treatment should be determined according to the clinicopathologic criteria and TNM edition used in the relevant pivotal trials, together with applicable regulatory indications	I	100% (20/20)
	2	Preoperative contrast-enhanced chest CT should be performed in all patients for anatomic staging. FDG-PET/CT should also be obtained, when available, in patients with potentially curative clinical stage IB–III disease or when nodal or distant staging may alter management. Invasive mediastinal staging should be considered in patients with suspicious mediastinal nodes or an increased risk of occult N2 disease, including central tumours, clinical N1 disease, or tumours >3 cm. EBUS/EUS-guided sampling should generally be the initial approach, with surgical staging considered when endosonographic findings are negative but suspicion remains high	I	90% (18/20)
	3	Brain MRI should be performed before surgery in patients with clinical stage II or higher NSCLC. If MRI is not feasible, contrast-enhanced brain CT may be used as an alternative	IIa	100% (20/20)

	4	In patients with suspected stage I–III NSCLC, pathological confirmation should be obtained before treatment whenever feasible, particularly before systemic therapy or nonsurgical definitive treatment. However, in medically operable patients with a highly suspicious, technically resectable lesion, surgery may provide both diagnosis and definitive treatment when preoperative biopsy is unsafe, technically unsuccessful, or unlikely to change management. Histopathological diagnosis should follow the 2021 WHO classification	I	90% (18/20)
	5	Testing for EGFR mutation, ALK rearrangement, and PD-L1 expression should be performed on the preoperative biopsy specimen to inform multimodality treatment planning. If preoperative testing cannot be completed, biomarker testing should be performed on the surgical specimen to guide adjuvant treatment.	I	90% (18/20)
		Next-generation sequencing should be considered when feasible	IIb	
	6	To determine surgical candidacy, patients should undergo detailed staging according to the AJCC/UICC TNM 9th edition together with stepwise cardiopulmonary functional assessment. Spirometry and DLCO should be performed as baseline assessments, followed, when indicated, by predicted postoperative lung function and exercise testing. CPET should be reserved for patients with impaired functional reserve, significant cardiopulmonary disease, or otherwise uncertain operative risk. Where these investigations are not available, alternative assessments may be used according to institutional resources and local practice	I	100% (20/20)
	7	Multidisciplinary team discussion should be applied to all patients with clinical stage II or higher NSCLC before surgery to guide multimodality treatment planning. For patients with clinical stage IB disease, MDT discussion should be considered when staging, resectability, or treatment strategy is uncertain. At a minimum, MDT discussion should be ensured for complex or borderline cases	IIa	100% (20/20)
Part 2: Consensus on surgery and postoperative surveillance				

	8	Surgery is indicated for medically operable patients with technically resectable NSCLC. Lobectomy is the standard surgical treatment for NSCLC. Surgery should achieve an R0 resection, defined as microscopically negative margins together with systematic lymph node dissection or selective nodal dissection	I	100% (20/20)
	9	When the goal is an R0 resection, minimally invasive thoracic surgery, particularly video-assisted thoracoscopic surgery (VATS) and, where appropriate, robotic-assisted thoracic surgery (RATS), should be preferred in suitable patients because it reduces postoperative morbidity without compromising oncologic adequacy in experienced hands	IIa	100% (20/20)
	10	Sublobar resection may be considered (1) in appropriately selected patients with a peripheral tumour measuring 2 cm or less, appropriate tumour imaging characteristics, and carefully confirmed node-negative disease, and/or (2) in patients who are not suitable candidates for lobectomy because of limited pulmonary reserve or substantial comorbidity. When a sublobar approach is selected, an adequate parenchymal margin, preferably at least 2 cm or at least equivalent to the tumour diameter, should be achieved together with appropriate intraoperative hilar and mediastinal nodal assessment. Anatomical segmentectomy is generally preferred when technically feasible, preferably in centres with adequate technical capability to ensure R0 resection and after MDT discussion	IIa	100% (20/20)
	11	Curative-intent pulmonary resection, whether by lobectomy or segmentectomy, should include appropriate lymph node dissection or sampling. This may be achieved through systematic lymph node dissection or systematic nodal sampling; at minimum, at least three mediastinal nodal (N2) stations, including the subcarinal station when anatomically appropriate, and at least one hilar or intrapulmonary nodal (N1) station should be sampled or dissected. When segmentectomy is performed, the same minimum hilar and mediastinal nodal assessment should apply	IIa	90% (18/20)

	12	Postoperative follow-up should be conducted by dedicated lung cancer specialists, such as thoracic surgeons, medical oncologists, or pulmonologists. Chest CT should be performed approximately every 6 months during the first 2 years and annually thereafter. Routine FDG-PET/CT surveillance is not recommended; FDG-PET/CT should be reserved for suspected recurrence or clarification of equivocal conventional imaging. Annual chest CT may be continued beyond 5 years for detection of second primary lung cancers	I	100% (20/20)
	13	SBRT should be offered as a curative-intent treatment for medically inoperable patients with node-negative early-stage NSCLC.	I	100% (20/20) ^a
	14	In medically operable patients with node-negative early-stage NSCLC who decline surgery after appropriate counselling, SBRT may be considered following multidisciplinary discussion.	IIb	100% (20/20) ^a
	15	Conventionally fractionated radical radiotherapy is an appropriate alternative in patients with early-stage NSCLC who are not candidates for SBRT	IIb	100% (20/20)
Part 3: Consensus on neoadjuvant and perioperative therapy				
	16	Technical resectability and medical operability should be established before neoadjuvant treatment is initiated. Neoadjuvant therapy should not be used routinely as a strategy to convert technically unresectable NSCLC into resectable disease	I	82% (14/17)

17	Neoadjuvant or perioperative immunotherapy combined with platinum-based chemotherapy should be considered as a preferred treatment choice for medically operable patients who have been selected and discussed carefully in the MDT to confirm that they have technically resectable stage IIIA or selected stage IIIB NSCLC and who meet the clinicopathologic eligibility criteria and TNM staging definitions used in the relevant pivotal trial, together with applicable regulatory criteria. Patients must not have N3 disease, EGFR mutations, ALK rearrangement, or contraindications to immunotherapy; in general, this recommendation applies regardless of PD-L1 expression	I	100% (17/17) ^b
18	Neoadjuvant or perioperative immunotherapy combined with platinum-based chemotherapy should be considered for medically operable patients with technically resectable stage II NSCLC who meet the clinicopathologic eligibility criteria and TNM staging definitions used in the relevant pivotal trial, together with applicable regulatory criteria. Patients should not have EGFR mutations or ALK rearrangements or contraindications to immunotherapy; PD-L1 expression is not an absolute eligibility requirement	IIa	100% (17/17)
19	Neoadjuvant-only and perioperative immunotherapy should be considered distinct treatment strategies in patients with resectable NSCLC. Durvalumab, pembrolizumab, and nivolumab are acceptable immune checkpoint inhibitor options when used according to the corresponding treatment strategy, with selection based on local regulatory approval, availability, reimbursement policy, affordability, institutional experience, and patient preference	I	100% (17/17)
20	Contrast-enhanced chest CT should be performed in all patients after neoadjuvant immunotherapy plus chemotherapy to reassess resectability	I	100% (17/17)

	21	Routine repeat brain imaging with CT or MRI before surgery is not required in asymptomatic patients after neoadjuvant immunochemotherapy. Repeat brain MRI should, however, be considered if new neurologic symptoms develop, surgery is substantially delayed, aggressive clinical behavior raises concern for interval progression, or other clinical concerns suggest possible intracranial disease	III	100% (17/17)
	22	Cases in which technical resectability or medical operability remains uncertain after neoadjuvant therapy should undergo repeat multidisciplinary review before proceeding to surgery	I	94% (16/17)
	23	The preferred interval between completion of neoadjuvant immunotherapy plus chemotherapy and surgery is approximately four to six weeks, provided treatment-related toxicities have adequately resolved and repeat assessment confirms surgical readiness, continued technical resectability and medical operability	I	100% (17/17)
	24	Pathologic complete response (pCR) and major pathologic response (MPR) should be standardised and incorporated into routine surgical pathology reporting after neoadjuvant therapy	IIa	100% (17/17)
	25	When a patient begins a trial-validated perioperative regimen, the planned postoperative immunotherapy should generally be administered if postoperative recovery and treatment-related toxicities permit. Postoperative immunotherapy should not be added routinely after a neoadjuvant-only regimen, and the incremental benefit of postoperative immunotherapy according to pCR or MPR remains uncertain	IIa ^c	100% (17/17)
	26	At present, circulating tumour DNA should not be used routinely as a clinical decision-making tool in the postoperative management of resectable NSCLC	III	100% (17/17)

	27	Patients who develop disease progression during or after neoadjuvant therapy should undergo complete restaging and repeat multidisciplinary team reassessment before any decision to proceed with surgery	IIa	100% (17/17)
Part 4: Consensus on adjuvant treatment				
	28	In resected NSCLC, the surgical specimen should undergo not only definitive pathological classification but also biomarker assessment for EGFR mutation, ALK rearrangement, and PD-L1 expression (if not already performed on the preoperative biopsy)	I	100% (17/17)
	29	Adjuvant systemic therapy after complete resection should be guided by pathologic stage, biomarker profile, prior treatment, and relevant trial and regulatory eligibility criteria. Chemotherapy, EGFR- or ALK-targeted therapy, and immune checkpoint inhibitors should be selected and sequenced according to the evidence and indications applicable to each specific therapeutic strategy	I	100% (17/17)
	30	Patients with completely resected stage II–IIIA NSCLC who are eligible for adjuvant chemotherapy should receive cisplatin-based adjuvant chemotherapy. In selected high-risk stage IB disease, cisplatin-based adjuvant chemotherapy may be considered. The use and sequencing of chemotherapy with subsequent biomarker-directed adjuvant therapy should follow the indication applicable to each treatment strategy	I	100% (17/17)
	31	Patients with completely resected EGFR exon 19 deletion- or exon 21 L858R-positive NSCLC who meet the ADAURA-defined eligibility criteria (stage IB–IIIA according to the AJCC/UICC seventh edition) and applicable regulatory criteria should receive adjuvant osimertinib 80 mg once daily for 3 years. In patients with stage II–IIIA disease who are eligible for cisplatin-based adjuvant chemotherapy, chemotherapy should generally be administered before osimertinib. In stage IB disease, or when cisplatin is contraindicated, the decision regarding adjuvant chemotherapy should be individualized	I	100% (17/17)

32	Patients with completely resected ALK-positive NSCLC who meet the trial-defined stage eligibility criteria (stage IB with tumours measuring at least 4 cm, stage II, or stage IIIA according to the AJCC/UICC seventh edition) and applicable regulatory criteria should receive adjuvant alectinib 600 mg twice daily for 2 years. Platinum-based adjuvant chemotherapy is not required when alectinib is selected as the postoperative systemic treatment	I	100% (17/17)
33	In patients with completely resected EGFR-negative and ALK-negative NSCLC, adjuvant atezolizumab or pembrolizumab may be considered in appropriately selected patients according to the distinct trial and regulatory eligibility criteria applicable to each agent. Patient selection and treatment should account for the relevant TNM edition, prior adjuvant platinum-based chemotherapy, PD-L1 requirements where applicable, treatment duration, and current regulatory indications	IIa	100% (17/17)
34	Postoperative radiotherapy (PORT) is not routinely recommended after complete (R0) resection. Selected high-risk situations may be considered individually through multidisciplinary discussion	I	100% (17/17)
35	Postoperative radiotherapy (PORT), commonly 60 Gy in 30 fractions, may be considered after microscopically incomplete (R1) resection when re-resection to achieve negative margins is not feasible or appropriate, following multidisciplinary discussion, and the sequencing of postoperative radiotherapy with systemic therapy should be individualized. Macroscopically incomplete (R2) resection should be managed separately through multidisciplinary evaluation	IIa	100% (17/17)

Note: Agreement percentages reflect the original formal voting results. Post-consensus revisions were not re-voted and are indicated: ^aStatements 13 and 14 were derived from one original statement (100% agreement, 20/20; Class IIb) and subsequently separated for clarity. Statement 13 was reclassified as Class I, while Statement 14 retained Class IIb; ^bThe wording and scope of Statement 17 were refined post-consensus; the reported agreement refers to the original voted version; ^cCurrent Statement 25 was reclassified from Class I to Class IIa post-consensus; the reported

agreement refers to the original voted version. AJCC, American Joint Committee on Cancer; ALK, anaplastic lymphoma kinase; CPET, cardiopulmonary exercise testing; CT, computed tomography; ctDNA, circulating tumour DNA; DLCO, diffusing capacity of the lung for carbon monoxide; EBUS, endobronchial ultrasound; EGFR, epidermal growth factor receptor; EUS, endoscopic ultrasound; FDG-PET/CT, fluorodeoxyglucose positron emission tomography/computed tomography; MDT, multidisciplinary team; MPR, major pathologic response; MRI, magnetic resonance imaging; NSCLC, non-small cell lung cancer; pCR, pathologic complete response; PD-L1, programmed death ligand 1; PORT, postoperative radiotherapy; RATS, robotic-assisted thoracic surgery; SBRT, stereotactic body radiotherapy; TNM, tumour, node, metastasis; UICC, Union for International Cancer Control; VATS, video-assisted thoracoscopic surgery; WHO, World Health Organization.