Sixth International Joint Meeting on THORACIC SURGERY

Barcelona - 20th, 21st and 22nd November 2024
Auditorio Foment del Treball Nacional. Barcelona (Spain)

11th International Meeting on General Thoracic Surgery
Clínic Barcelona | Universitat de Barcelona | Hospital Universitari Sagrat Cor

5th Meeting of the Thoracic Oncology, Thoracic Surgery, Techniques & Transplant, Respiratory Nursing and Respiratory Physiotherapy Areas of the Spanish Society of Pneumology and Thoracic Surgery (SEPAR)
Sociedad Española de Neumología y Cirugía Torácica (SEPAR)

10th International Workshop on Surgical Exploration of the Mediastinum and Systematic Nodal Dissection
Hospital Universitari Mútua Terrassa | Universitat de Barcelona

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3rd Joint Meeting of the Spanish Society of Thoracic Surgery (SECT)
SECT Sociedad Española de Cirugía Torácica

30th Congress of the "Asociación Iberoamericana de Cirugía Torácica" AIACT

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PERSISTENT N2 IS NOT A CONTRAINDICATION TO SURGERY FOR LUNG CANCER

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Surgical multimodal management of stage IIIA-N2 non-small cell lung cancer (NSCLC) has undergone a tremendous change with the introduction of chemo-immunotherapy in the neoadjuvant and perioperative setting. Molecular pathology and biomarkers gain increasing importance for determining personalized therapeutic strategies as well as for prognostic stratification.

Already prior to the introduction of immunotherapy in the curative setting subgroups of patients with persistent N2 disease were identified that showed a clear benefit from surgery. Superior long-term outcomes have repeatedly been demonstrated in patients with single station N2 compared to disease in multiple stations. This is also reflected in the current TNM9 staging with a refined N2 stage grouping in N2a (metastasis(es) in a single ipsilateral mediastinal or in the subcarinal nodal station) and N2b (metastases in multiple ipsilateral mediastinal nodal stations with or without involvement of the subcarinal nodal station).

The correlation between imaging-based mediastinal restaging after immunotherapy and pathological response rates is moderate. Thus, the radiographic judgment on persistent nodal disease is unreliable, and no clear guidelines on invasive mediastinal restaging after neoadjuvant chemo-immunotherapy have been established. Data on the prognostic impact of persistent nodal disease in modern multimodal treatment regimens are not yet consistent and sufficiently granular to allow definite conclusions. Current efforts are directed at obtaining a consensus definition of surgical resectability in stage III disease. In view of the excellent pathological response rates after neoadjuvant chemo-immunotherapy and the encouraging results of perioperative systemic treatment approaches persistent N2 disease should not routinely exclude patients from curative intent surgical resection.

References

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