Sublobar Resection is Underutilized – Con

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Financial Disclosure

• Conflict of interest …
• Coaching ….. Teaching …
• Now get paid do so …. 
• Honorarium from Intuitive, Ethicon, Covidian, KCL, to proctor, coach, pinnacle 
• Also I devised PRIIME …
• Written book …
SUPER PERFORMING
AT WORK AND AT HOME

The Athleticism of Surgery and Life

Available on amazon.com
Chinese, Japanese
Great Debate

My View

• My stance …
• Lobectomy not used enough, esp. MIS lobectomy, nor is LN dissect
• Part problem definition
• If RML is a lobectomy, why is a lingulectomy a segmentectomy?
Great Debate
Evidence Based Decision Making

Current data not A the Q

• Nor will the long expensive study ongoing ..
• He CALGB 4051
• Lets review its design …
• PRIMARY OBJECTIVES:
  • I. To determine whether disease-free survival (DFS) after sublobar resection (segmentectomy or wedge) is non-inferior to that after lobectomy in patients with small peripheral (=< 2 cm) non-small cell lung cancer (NSCLC).
Wedge resection or segmentectomy may be less invasive types of surgery than lobectomy for non-small cell lung cancer and may have fewer side effects and improve recovery.
SECONDARY OBJECTIVES:

I. To determine whether overall survival (OS) (after sublobar resection) is non-inferior to that after lobectomy.

II. To determine the rates of loco-regional and systemic recurrence (exclusive of second primaries) after lobar and sublobar resection.
• III. To determine the difference between the two arms of the study in pulmonary function as determined by expiratory flow rates measured at 6 months post-operatively.
• IV. To explore the relationship between characteristics of the primary lung cancer, as revealed by pre-operative computed tomography (CT) and positron emission tomography (PET) imaging, and outcomes.
V. Determine the false-negative rate of preoperative PET scan for identification of involved hilar and mediastinal lymph nodes.
• VI. Assess the utility of annual follow-up CT imaging after surgical resection of small stage IA NSCLC.II
• ARM I: Patients undergo lobectomy by open thoracotomy or video-assisted thoracoscopic surgery (VATS).

• ARM II: Patients undergo a wedge resection or anatomical segmentectomy by open thoracotomy or VATS.
After completion of study treatment, patients are followed up every 6 months for 2 years and then annually for 5 years.
How study interpreted .. Hx tells us a lot .. Look at Ln study …

• Some interpret: can take no LN
• Segmentect as good as lobe…
• When study over: general surg. do wedges, take no LN’s
Real Issues

• Location, location, location …
• Segmentectcs not the same …
• Some segmentectomy difficult
• Some not really segments ..
• Lobes different: RUL, RML, LUL
• Sup. segm. different basilar segm
Real Competition
Not Lobectomy - Its SBRT

• True comp debate .. SBRT
• Segmentectomy will have to be chosen more .. b./c reality
• Less M/M, better PFT’s
• Lung Ca screening → smaller nod
• Hard find some nodules
• Miss them on segmentectomy
• Are PFT really better?
• Lobectomy safer in many pts
• Our study ....
2/10 -12/14 - 100 pts OR robotic lobe
7 pts converted to robotic lobectomy
Remaining 93 patients had an anatomic robotic segmentectomy
No conversions to thoracotomy
Lung Ca - 79, M1 -10, fungal in 4 and others in 7.
Median age was 69 (50 men)
Median blood loss was 20 cc (range of 10 – 120)
Median number of lymph nodes removed was 19,
Median Tot Op T - 1.47 hrs (88 minutes)
Median hospital stay – 2 days
Major M/M – 2 pts…(pneumonia)
All had an R0 resection
0 – 30 day and 90-day mortality
79 pts -lung cancer, median follow-up was 30 months, three patients (3.9%) had recurred in the operated lobe