believe the decline in the phospholipid/protein ratio seen in infants receiving bypass is indicative of lung injury. Finally, by stating that our data support the findings of McGowan and colleagues,³ we did not mean to imply that we found the same alteration in surfactant composition that was shown in this investigation. We were able to demonstrate a quantitative difference in surfactant, whereas McGowan and associates showed a qualitative difference, albeit in a different patient population.

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Complete resection: Yes or no?

To the Editor:

We read with great interest the article titled "Lobe-Specific Extent of Systematic Lymph Node Dissection for Non-Small Cell Lung Carcinomas According to a Retrospective Study of Metastasis and Prognosis" by Asamura and associates (*J Thorac Cardiovasc Surg* 1999;117:1102-11). The authors mentioned that subcarinal lymphadenectomy is not always necessary for tumors of the right upper lobe and left upper segment. Their argument is based on the retrospective analysis of their data, which consists of more than 166 cases. However, we question whether these resections can be classified as "complete resection."

The definition of "complete resection" in the management of non-small cell lung cancer is not uniform in the literature. The definition provided by Mountain¹ has been widely accepted in the Western world. In this definition, resection can be considered complete when the highest station sampled at thoracotomy is tumor free and extranodal disease is not detected in any of the mediastinal nodes. According to the definition provided by the National Cancer Center in Japan,² all the mediastinal stations where tumor can spread

should be removed. Thus more radical node dissection is required to perform a complete resection according to the Japanese definition.

Surgical resection can be beneficial only if the resection is complete. A clearly defined "complete resection" is mandatory, not only as a selection criterion for surgery but also for the postoperative classification of the patients. Otherwise, it is impossible to detect the positive effect of surgery in the different stages of the disease. We wonder whether Asamura and associates would consider any resection to be complete without examining all mediastinal nodes.

Asamura and associates argued that subcarinal lymph node dissection is not necessary for tumors localized to the right upper lobe and upper division of the left upper segment because single-station metastases to station 7 are rare. We wonder how the authors can detect multiple-station metastases, 37% (20/54) of which occur on the right and 50% (17/34) on the left, without examining all mediastinal stations. They reported that tumor spread to station 7 was detected in 12% to 13% of their patients. We think that regardless of multiple-station or single-station disease, this is too high a percentage to be neglected. Thus, despite their conclusion, their data indicate that subcarinal lymphadenectomy should be performed, which is a relatively easy procedure during thoracotomy.

A new definition for "complete resection" is urgently needed. We agree with the authors that re-evaluation of the mediastinal dissection on the basis of the data collected may be necessary, but the concept of lung resection for non-small cell lung cancer should not be changed without the definition of complete resection being revised. We argue that lung resection for non-small cell lung cancer without systematic lymph node dissection should not be performed until a new definition is provided.

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Reply to the Editor:

We appreciate the interest expressed by Kutlu, Sayar, and Metin in our consideration of the lobe-specific extent of systematic lymph node dissection for lung cancer.¹ This has been a point of discussion among thoracic surgeons for a couple of decades.

Their question can be summarized as follows: Can a pulmonary resection be regarded as a "complete resection" if some mediastinal nodes are not examined? Indeed, we have