stenting, the timing and indications for an early stage 1 or comprehensive stage 2, the use of a reverse Blalock-Taussig shunt, and definitions of hybrid failure with the need for conversion to a traditional palliation pathway all differ across centers. Trezzi and colleagues suggest that the primary indication for a stage 1 Norwood following a hybrid procedure is failure of hybrid palliation. Before this transition to a traditional palliation pathway is labeled a failure, it seems necessary to understand the intent of the hybrid approach in these patients. In our report, although some patients underwent conversion to stage 1 Norwood as a result of residual lesions (ie, progressive gradient across the stent or retrograde flow across the distal arch), many underwent a planned Norwood procedure once the contraindication for surgery had resolved (ie, intracranial bleed, necrotizing enterocolitis, or renal dysfunction). We submit that in this scenario the hybrid was not a failure but rather a success, considering that the objective was achieved.

We¹ and others⁴ have reported the use of branch pulmonary artery banding as a stabilizing maneuver in patients presenting in extremis. In these cases, we often plan to proceed to a traditional stage 1 Norwood as soon as the patient's hemodynamic parameters are stabilized. Because of the reduction in the duration of branch pulmonary artery banding, we believe this limits the risk of branch stenosis.⁵ Furthermore, because patients are maintained on prostaglandins rather than having a ductal stent implanted, the arch reconstruction is no more challenging than in a primary stage 1. However, based on individual patient characteristics and our center's experience and strengths, we select the most appropriate palliation strategy for each patient. We continue to advocate tailoring the palliation strategy to the patient, rather than employing a 1-size-fits-all approach. Whether subsequent analyses will identify subgroups of patients who will benefit from particular strategies across centers remains unclear. Until then, it remains important to critically evaluate both patient selection and palliation strategy as we search to enhance the survival of these challenging patients.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.05.016>

DO LUNG SECONDARY NODULES ALWAYS MEAN METASTASIS?

To the Editor:

We read with interest the recent article by Stiles and colleagues¹ about the prognostic impact of secondary nodules (SNs) in patients submitted to lung resection for non-small cell lung cancer. The finding of SNs at preoperative computed tomographic (CT) scan for early-stage lung cancer is a frequent occurrence. Unfortunately, their pathologic diagnosis is often difficult or impossible. The decision whether to suspend surgery, considering the nodes to be either benign or second primary malignancy rather than metastatic, is based exclusively on surgeon personal experience. As underlined by Ng,² Stiles and colleagues¹ suggested not suspending surgery, despite the impossibility to exclude a metastatic nature of SNs. In fact, according to their data, the rate of SNs detected on initial CT scans for dominant lung tumors referred for surgery was high (>50%), but the rate of malignancy in these nodules was low (13% of total SNs resected). Moreover, Stiles and colleagues¹ reported that survival was not influenced by SNs and that, surprisingly, morphologic characteristics according to CT (solid or nonsolid nodules) were not predictors of malignancy at multivariate statistical analysis.

Our concerns with their results are 2-fold.

First, this is a retrospective study. The low rate of malignancy in resected SNs may therefore have been influenced by some elements of surgical judgment in recruiting patients. In other words, patients were referred for surgery despite SNs because those SNs were already considered benign, probably on the basis of further information (patient age, clinical history, smoke attitude, nodal status, absence of nodule growth, etc).

The second concern is about tumor histologic type. In fact, 105 SNs (77%) were solid, and only 21 (15%)

were ground-glass opacities at CT scan. It is a common opinion that ground-glass opacities have a higher probability of being malignant than do solid nodules. These population characteristics could have influenced both the low rate of malignancy detected and the favorable survival.

To conclude, the results of Stiles and colleagues,¹ the overall 5-year survival (which was not different among all patients with or without SNs), and the prognostic influence of nodule size and side are interesting and useful for current clinical practice. Further prospective data, however, are necessary. Moreover, we think that ground-glass opacities, in contrast to solid nodules, are multifocal tumors, and different criteria should therefore be adopted for their treatment, as suggested by Gu and associates³ in a recent article.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.01.037>

SECONDARY NODULES: EVALUATE CAREFULLY BUT DO NO HARM Reply to the Editor:

My coauthors and I thank Baisi and colleagues for their commentary on our recent article.¹ In it, we

described the fate of secondary nodules identified by computed tomographic scan in patients undergoing resection for non-small cell lung cancer. In this analysis, we found that although 50% of our patients had secondary nodules, only a minority of these (13%) were definitively found to be malignant. We agree with Baisi and colleagues that the retrospective evaluation of this consecutive group of patients is an imperfect substitute for a prospective analysis. It is possible that some patients found to have malignant secondary nodules never made it to our surgical clinic. We suggest, however, that patients with undiagnosed secondary nodules should at least undergo surgical consultation. Certainly, as shown by the higher rate of malignancy in resected nodules (39%), surgical judgment is perhaps the best predictor of malignancy in these frequently found nodules. Regarding the suggestion that ground-glass opacities may be underrepresented in our series, we point out that our incidence of these nodules (15%) is remarkably similar to that observed in large-scale screening studies. As recently reported using data from the Netherlands Leuven Longkanker Screenings Onderzoek (NELSON) trial, most of these subsolid pulmonary nodules disappear, and only a very small minority develop into clinically manifest malignancies.²

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<http://dx.doi.org/10.1016/j.jtcvs.2015.03.035>