preoperative radiation and chemotherapy), slants the recommendation against pneumonectomy (especially right-sided pneumonectomy). My impression is that the decrease in pneumonectomy volume may also be related to the presence of a multidisciplinary tumor board at high-volume medical centers. I believe that the same argument could be made regarding wedge resection, because a multidisciplinary tumor board would be expected to favor segmentectomy relative to a wedge resection.

It would be interesting if Camposilvan and colleagues¹ were to review their data to determine whether the presence or absence of a multidisciplinary tumor board also correlated with the number of pneumonectomies and wedge resections performed at each institution and with the surgeon's volume.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.10.110>

**THE EFFECT OF SURGEON
VOLUME ON
PROCEDURE SELECTION IN
NON-SMALL CELL LUNG
CANCER SURGERIES
Reply to the Editor:**

Thank you for the opportunity to respond to Dr Baciweicz's letter, which makes a

Author has nothing to disclose with regard to commercial support.

very good point on the value of multidisciplinary tumor boards (MDTs). I completely agree with him that the healthy culture of collaboration and discussion provided by these groups allows for the improvement of patient care. Furthermore, that discourse across traditional silos of care allows for us all to reevaluate our plans and acknowledge valuable options, which are sometimes minimized or discarded and can be opaque to us when we are working in isolation. Regardless of stage, all patients with non-small cell lung carcinoma in the United Kingdom are discussed in the MDT forum, and here in Ontario, this is the recommended protocol. Functionally, managing this approach for all patients is too unwieldy for us, and typically those rounds are populated by the cases highlighted in this paper—those whose management can be more heterogeneous. But a danger arises in excluding from conversation those cases that we deem too “straightforward.”

Although I completely agree with Dr Baciweicz on the value of including MDT discussion and other factors in the analysis, to protect anonymity, the data are such that we cannot know if the patients were discussed or treated in an institution that used MDT rounds. Thus, we are not able to answer his valuable question.

I do think that this paper, among others, highlights the issues relating to surgeon preferences and choices. Although reflecting upon this aspect of the process may be uncomfortable, it is fundamental to improving our outcomes and achievements. By humbly identifying those areas that may influence our decision making, and optimizing those variables that are modifiable, we can hope to improve care of the patients.

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<http://dx.doi.org/10.1016/j.jtcvs.2016.01.014>