Authors have nothing to disclose with regard to commercial support.

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In summary, we hypothesize that postoperative chemotherapy is noninferior to neoadjuvant chemotherapy for N2 NSCLC and call for a large multicenter randomized trial to answer this question. We recognize the inherent challenges in conducting such a trial; however, the implications on reducing patient morbidity, costs, and resource use would be immense.

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HECATE: THE MANY FACES OF N2 DISEASE

Reply to the Editor:

In their letter to the editor, Pramesh and colleagues¹ propose 2 substantial changes to the management of N2 disease based on a recent paper by Yang and colleagues,² which evaluated outcomes after lobectomy in patients with unsuspected pN2 disease in the National Cancer Database, providing further support for proceeding with resection followed by adjuvant chemotherapy. Pramesh and colleagues¹ hypothesize that adjuvant chemotherapy for preoperatively diagnosed N2 disease will have equivalent outcomes to neoadjuvant chemotherapy. They should be cautious, however, about extrapolating these findings that compare unsuspected pN2 disease in postsurgical patients undergoing mediastinal lymph node dissection with cN2 disease diagnosed by clinical staging alone. The authors propose a multicenter trial testing this hypothesis for clinical N2 disease. Boffa and colleagues³ evaluated

patients with cN2 disease in the National Cancer Database and found no difference in survival between those undergoing neoadjuvant or adjuvant chemotherapy with complete resection, supporting the authors' proposal for a clinical trial.

On the basis of their hypothesis, Pramesh and colleagues¹ propose that preoperative invasive mediastinal staging would no longer be necessary and could be reserved for fludeoxyglucose-avid contralateral mediastinal nodes. In the most recent National Comprehensive Cancer Network and European Society of Thoracic Surgeons guidelines, patients with peripheral cN0 tumors ≤ 3 cm do not require invasive mediastinal staging because of a low risk of occult mediastinal disease. Patients with cN1 disease, central tumors, increased tumor fludeoxyglucose uptake, and adenocarcinomas, however, have a greater risk of N2 and N3 disease.⁴ Although most well-staged cN0-1/pN2 patients will have single-station, microscopic disease, the clinical N2 patients the authors propose to study without mediastinal staging would be more likely to have occult multistation N2 or N3 disease, which have a poorer prognosis, and N3 disease should be treated with definitive chemoradiation.

N2 disease is heterogeneous, ranging from occult to clinically suspected N2 to bulky disease and from single to multistation disease, making study comparisons and the uniform application of treatment recommendations difficult. Gomez-Caro and colleagues⁵ found unsuspected N2 disease in 14.4% of patients staged cN0 and in 4.8% with multistation N2 disease. Cho and colleagues⁶ found a decreased 5-year survival with occult multistation N2 disease of 36% versus 67% for single-station disease. Size >3 cm, cN1, adenocarcinomas, and middle lobe tumors were predictors of multistation disease, and they suggest that these patients should be staged aggressively.

Like Hecate, the 3-headed Greek goddess of the crossroads, it is important to recognize the many faces of N2 disease in choosing which pathway to follow. Accurate mediastinal staging remains important in defining the extent of disease, guiding treatment, and determining prognosis, especially in trials, so results can be better compared between studies. The extent of mediastinal disease should be considered in deciding a treatment option for N2 disease. Although studies support a role for surgery in the multimodal treatment of N2 disease, the exact role continues to be defined. Recent papers suggest a benefit after surgery and adjuvant chemotherapy for occult N2 disease and provide an opportunity for trials evaluating the primary role of surgery in N2 disease, focusing on

preoperatively proven single-station or microscopic N2 disease.

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Notice of Correction

Re: Yang B, DeBenedictus C, Watt T, Farley S, Salita A, Hornsby W, et al. The impact of concomitant pulmonary hypertension on early and late outcomes following surgery for mitral stenosis. *J Thorac Cardiovasc Surg.* 2016;152:394-400.e1.

In the above-mentioned article the middle initial of Donald Likosky is missing. The author's name should read Donald S. Likosky, PhD. The corrected author list is reprinted below.

Bo Yang, MD, PhD, Christina DeBenedictus, BS, Tessa Watt, MD, Sean Farley, BS, Alona Salita, BS, Whitney Hornsby, PhD, Xiaoting Wu, PhD, Morley Herbert, PhD, Donald S. Likosky, PhD, and Steven F. Bolling, MD