Authors have nothing to disclose with regard to commercial support.

chemotherapy, with or without radiation therapy, could be administered after surgery. If adjuvant therapy was not provided, outcomes were significantly worse for the resected, surprise N2 patients. The good news suggested by the work of Yang and colleagues is that surprise N2 patients might be helped by surgery even if induction therapy has been “accidentally” dismissed; however, many biases are present in the study.

In our opinion, the most important one is that the authors were not able to distinguish patients with suspected N2 who underwent induction therapy with successful downstaging from those who continued to have N2 disease. Despite the claim by some that the prognosis of cN2 induction/surgery patients is not influenced by N2 downstaging if complete nodal dissection can be achieved,² there is strong evidence that surgery is not successful equally in those with persistent versus nonpersistent N2 disease.

Moreover, we have concerns about the authors’ suggested role of intraoperative nodal frozen section before lobectomy. They suggested that N2 frozen section is useless because its result does not change the prognosis if lobectomy and following adjuvant therapy can be performed; however, because they were not able to distinguish between single or multiple station c/pN2, they also added that N2 frozen section could be performed when multiple stations N2 disease is suspected. In fact, the role of surgery is controversial when N2 involvement is widespread.

Our first question is thus: How can a surgeon intraoperatively decide that a patient, who may be fit for a lobectomy, is or is not eligible for postresection adjuvant therapy? The second question is: When should surgeons intraoperatively suspect multiple N2 disease and thus do a complete lymphadenectomy with an immediate frozen section? If preoperative computed tomography, positron emission tomography scan, and endobronchial ultrasonography biopsy already have been performed adequately to exclude N2 disease, what would prompt a frozen section on a lymphadenectomy specimen?

In our opinion, it currently is possible to obtain an accurate preoperative nodal staging that is so reliable that the occasion of macroscopic disease at surgery is very unlikely. Therefore, intraoperative preresection nodal frozen section is probably useful only in few rare cases in which suspected multiple N2 disease could not be proved by endobronchial ultrasonography.

Despite these doubts, the paper is interesting, especially because this work appears to strengthen the role of surgery

and adjuvant therapy in case of locally advanced non–small cell lung cancer.

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2. Baisi A, De Simone M, Raveglia F, Cioffi U. Which is the role of surgical resection for NSCLC in case of unexpected N2? *Ann Thorac Surg.* 2014;98:2271.

<http://dx.doi.org/10.1016/j.jtcvs.2016.07.048>

**FROZEN SECTION
OF N2 NODES IS
INVALUABLE
WHENEVER
UNEXPECTED**

SUSPICIOUS OPERATIVE FINDINGS ARE ENCOUNTERED

Reply to the Editor:

We appreciate the insight on our study expressed by Baisi and colleagues.¹ Their comments are a reflection of the complexity of how to optimally manage patients with non–small cell lung cancer and N2 disease. We disagree with their statement that we suggest that intraoperative frozen section is useless. On the contrary, we feel strongly that intraoperative frozen section is invaluable in many cases of non–small cell lung cancer and in fact is one of the tools that increases the utility of surgery over other modalities. In our study, we only commented that routine frozen section of N2 nodes during lobectomy is not necessary in all patients who do not have clinically suspicious nodes presurgery or do not have grossly abnormal nodes found during surgery.

With regard to their question of how a surgeon can evaluate whether a patient could tolerate adjuvant therapy, we feel this is simply an extension and re-evaluation of all the clinical patient characteristics (eg, age, pulmonary function, comorbidities, activity and functional levels, frailty, etc) that the surgeon must have evaluated extensively during assessment of whether the patient was an appropriate surgical candidate in the first place. Baisi and colleagues also had a question regarding when surgeons should intraoperatively suspect multiple N2 disease and perform a complete

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mediastinal lymphadenectomy with intraoperative frozen sections. In our practice, if preoperative imaging suggests mediastinal N2 disease, we would perform an endobronchial ultrasound (EBUS) or mediastinoscopy before lobectomy. If the EBUS or mediastinoscopy is negative, then we would proceed with a lobectomy with complete lymphadenectomy and would not send further frozen sections of N2 lymph nodes.

We agree with the authors that it is probably a rare occurrence to have unexpected macroscopic N2 disease discovered intraoperatively after negative computed tomography/positron emission tomography imaging and negative EBUS/mediastinoscopy. In this instance, when abnormal-appearing mediastinal lymph nodes are found unexpectedly in the operating room, we usually submit intraoperative frozen sections of the N2 lymph nodes to confirm whether

cancer is present and also establish the extent of mediastinal disease. We do feel, however, that based on our study's results, it is reasonable for surgeons to continue with lobectomy after they consider the extent of mediastinal disease and the patient's overall medical condition.

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1. Baisi A, Raveglia F, Cioffi U. Does N2 frozen section make sense in cN0 non-small cell lung cancer patients? *J Thorac Cardiovasc Surg.* 2016;152:1642-3.

<http://dx.doi.org/10.1016/j.jtcvs.2016.08.048>

Notices of Correction

Re: de Kerchove L, Jashari R, Boodhwani M, Duy KT, Lengelé B, Gianello P, et al. Surgical anatomy of the aortic root: Implication for valve-sparing reimplantation and aortic valve annuloplasty. *J Thorac Cardiovasc Surg.* 2015;149:425-33.

In the above-mentioned article, the surname of the seventh author was incorrectly identified and misspelled. The author's correct surname is "Mosala Nezhad." The corrected author list is reprinted below.

Laurent de Kerchove, MD, PhD, Ramadan Jashari, MD, Munir Boodhwani, MD, MMSc, Khanh Tran Duy, Ir, PhD, Benoit Lengelé, MD, PhD, Pierre Gianello, MD, PhD, Zahra Mosala Nezhad, MD, Parla Astarci, MD, PhD, Philippe Noirhomme, MD, and Gebrine El Khoury, MD

Re: Baek JS, Yu JJ, Im YM, Yun T-J. Outcomes of neonatal Ebstein's anomaly without right ventricular forward flow. *J Thorac Cardiovasc Surg.* 2016;152:516-21.

In the above-noted article, Asan Medical Center's university affiliation, University of Ulsan College of Medicine, was omitted from the author affiliations. The updated author affiliations are printed below.

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