Just buckle up

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Central Message

Lymph node dissection at the time of surgical resection should be as routine as putting on one's seat belt every time one gets in a car.

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In their article in this issue of the *Journal*, Cao and colleagues¹ conclude that lymph node dissection is associated with better survival of patients undergoing sublobar resection. More importantly, their review of the Surveillance, Epidemiology, and End Results (SEER) database highlights an unfortunate reality that continues to plague the surgical management of lung cancer: insufficient lymph node sampling or dissection at the time of surgery (44.6% of patients had no regional lymph nodes removed at the time of surgery). As Cao and colleagues¹ emphasize, we have ample evidence² to support the routine application of lymph node sampling or dissection. In fact, the importance of this element of the operation is indisputable, just like the concept of achieving negative margins.

Is there something particularly challenging about making nodal sampling or dissection routine in all lung cancer resections? Does the addition of this component to the operation add substantially to morbidity and mortality? Clearly not, yet we continue to read reports in the literature with astounding numbers of cases being performed in the absence of lymph node sampling or dissection.³⁻⁵ So, how to explain?

Perhaps it is possible to compare this situation to what happens each time we get in a car. If we plan to travel on a busy interstate, we are more apt to buckle up, because we expect to be traveling at high rates of speed. Comparably, as thoracic surgeons, if we have a patient with a 5-cm upper lobe tumor, we appreciate the patient's high risk of nodal involvement and thus the importance of a mediastinal node dissection.

Conversely, some people, forgo putting on their seat belts when getting in the car for a short trip, subconsciously thinking that because they know the roads well and will not be traveling far, the belt is not a necessity. But why not buckle up? It is a quick, simple act with proven benefits. Plus, accidents can happen anywhere, at any speed, and can be deadly. The same must also be said for lymph node sampling at the time of sublobar resection. A small cancer, just like that 5-mile trip to Target, is still a potentially life-limiting entity. For the dedicated thoracic surgeon,

resection in conjunction with a lymph node sampling or dissection should be no more difficult than buckling a seat belt.

In the end, Cao and colleagues,¹ in addition to reemphasizing the importance of nodal sampling or dissection, attempt to explain why it is not being done. But it is impossible to ascertain this from an entity like the SEER database. Explanations for human behavior that occurs in the face of evidence to the contrary is pervasive in all elements of life. For example, you can remind someone that of the 35,092 people killed in motor vehicle accidents in 2015, 48% were not wearing seat belts and that seat belts saved 13,941 lives in that same year—and yet there will be those who continue to ride without one.⁶ Likewise, we know that nodal sampling or dissection is essential to staging and impacts treatment—but, as Cao and colleagues¹ have reminded us, sometimes the easiest things are the hardest things to do.

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