Authors have nothing to disclose with regard to commercial support.

the number of nodal stations explored in lung cancer surgery helps us understand why it is difficult to achieve the international standards of complete resection, and we cannot agree more with them.¹ Sooner or later, the categories of the N component of the tumor, node, and metastases (TNM) classification of lung cancer will be on the basis of the quantification of nodal disease in addition to or instead of the anatomic location of the involved lymph nodes. If this innovation is included in future editions of the TNM classification of lung cancer, it will even be more important to precisely quantify nodal disease. The number of involved nodal zones, in the analyses performed for the 7th edition,² and the number of involved nodal stations, in the analyses for the 8th edition,³ showed that the number of involved zones and stations had prognostic implications. The number of involved lymph nodes and the lymph node ratio (ie, the number of involved lymph nodes divided by the total number of lymph nodes removed) also have prognostic relevance.⁴ If we are to quantify nodal disease in the future to determine the categories of the N component of the TNM classification, we certainly will have to be more accurate in performing systematic nodal dissection, in counting the number of involved lymph nodes, nodal zones, or nodal station, and in labeling the removed lymph nodes. Molnar⁵ designed a lymph node tray to facilitate labeling and handling of removed lymph nodes in the operating room and in the pathology department. Osarogiagbon and colleagues⁶ proposed the use of a specialized specimen collection kit for mediastinal lymph nodes that improved lymph node staging. If these devices are not used, the surgeon should identify individual lymph nodes and label them according to the lymph node map proposed by the International Association for the Study of Lung Cancer to facilitate their counting.⁷

The study by Drs Kneuert and Merritt and colleagues,⁸ and the reply from Drs Kneuert and Merritt to our comment¹ show that there is much room for improvement in intraoperative lymph node assessment. It is also clear that the intrinsic limitations of retrospective studies should be overcome in prospective studies, especially because the quantification of nodal disease, no doubt, will be used to define the anatomic extent of lung cancer.

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PREOPERATIVE PULMONARY REHABILITATION To the Editor:

I enjoyed the recent article by Gravier and colleagues¹ in the June issue of *The Journal of Thoracic and Cardiovascular Surgery*, “Effect of Prehabilitation on Ventilatory Efficiency in Non-Small Cell Lung Cancer Patients: A Cohort Study.” Our group did extensive outpatient preoperative pulmonary rehabilitation in patients with lung cancer with forced expiratory volume in 1 second < 1.56 L/s who underwent subsequent lung resection. The study compared those receiving preoperative pulmonary rehabilitation with a second group without any preoperative pulmonary therapy.

The group receiving pulmonary rehabilitation improved their forced expiratory volume in 1 second significantly

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before lung resection. The average intensive care unit stay, morbidity, and mortality, however, were unchanged between the cohorts.²

Gravier and colleagues¹ presented a more extensive plan of preoperative rehabilitation and a much more elegant measure of pulmonary function. Patients can be enrolled in preoperative rehabilitation, but their participation is effort dependent. How did the postoperative course and complications of the treated patients (whether more or fewer than 15 treatments) compare with those of patients who did not receive any preoperative therapy?

We await the results of current prospective efforts at preoperative pulmonary rehabilitation, including muscle training, avoiding smoking, and adjustment of patient medications, to see whether there will be a substantial effect on lung resection outcomes in patients with lung cancer.

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**REPLY:
PREHABILITATION
FOR INCREASING
VENTILATORY
EFFICIENCY BEFORE
LUNG RESECTION—
AMAZING CONCEPT,**

BUT WE ARE NOT THERE YET!

Reply to the Editor:

We thank you for the opportunity to comment on the letter to the Editor sent by Dr Baciewicz. We concur with Dr Baciewicz that the proposed comparison between the cohort of the study from Gravier and colleagues¹ and patients who did not receive preoperative prehabilitation in terms of postoperative course and clinical complications could be of interest. They could run this analysis with or without propensity matching with the 138 patients who did not

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receive pulmonary prehabilitation in their center during the same study period as a comparator. Nevertheless, this analysis would likely be underpowered because the small sample size in each subgroup. Moreover, conclusions drawn from this analysis, even if positive, should be viewed with caution, because the threshold of 15 sessions was decided on arbitrarily, more on the basis expert opinion than on the basis of robust statistical analysis (area under the curve, 0.68).

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**REPLY FROM THE
AUTHORS:
PREHABILITATION
VERSUS STANDARD
CARE—WHAT
IMPACT ON
COMPLICATIONS?**

Reply to the Editor:

We thank Dr Baciewicz for his interest in our article. Indeed, our retrospective cohort study of 50 patients focused on the impact of prehabilitation with analysis of cardiopulmonary exercise testing before and after prehabilitation. Results report that patients included in our prehabilitation program had better physiologic benefits and suggest fewer complications from 15 treatment sessions. As is underlined, however, there remains the question of comparison with patients who have not benefited