Dr Cerfolio discloses past relationships with C-SATS, Intuitive Surgical, Myriad G, and TEGO Corporation, and he is the president of ROLO-7 Consulting Firm, and the author of 2 books on leadership.

**REPLY FROM THE
AUTHORS:
ACCOUNTABILITY AND
LEADERSHIP
CHANGES CULTURE—
YES, EVEN FOR LYMPH
NODES**

Reply to the Editor:

The authors have raised several important and interesting points that are undoubtedly true. In general, we agree with their comments; our view on this issue is quite different and cuts to the concept of leadership. And to the uninitiated, this editorial might seem harsh, but our experience suggests that this is the best way to drive excellence and change culture in a health care system. The quality of patient care is the single most valued and important element of health care. Lymph node resection during lung cancer surgery is a quality metric of the surgeon not of the pathologist. Our view is summarized by the phrase, “Leaders take accountability for all variables and for all metrics or surrogates of quality that are under our control—great leaders inspire those around them to make the entire process under their control. We don’t point fingers or cast blame on others nor do we blur lines of attribution. Rather, we willingly accept all the variables that influence our outcomes even those that initially might not seem to be in our purview.” There can be no higher goal than providing our patients the best care possible, and this means optimizing any metrics that might reflect or be surrogates of quality patient care.

This takes us to thoracic lymph nodes. If the number of lymph nodes removed and/or the number of lymph nodes stations assessed is a surrogate of quality (and it is) then why would we as leaders NOT take full accountability for it? The removal of mediastinal and hilar thoracic lymph nodes and how they are labeled during cancer surgery is a perfect example of our philosophy.

Yes, it is true that many surgeons “remove the paratracheal lymph nodes en bloc”¹ but the labeling of them as such is not the pathologist’s fault. It is the surgeon’s fault. The specimens should be labeled as, for example, “3 lymph nodes removed from station 4R.” Likewise, those removed from the 2R station should be separately labeled, as for example, “5 lymph nodes removed from station 2R.”

Yes, it is true that surgeons often take the 5 and 6 lymph nodes out en block and count them as a packet. Again, the

surgeon and his or her team should label it as, “4 lymph nodes removed from station 5,” etc.

Yes, it is true that many pathologists don’t look at N1 lymph nodes in the resected specimen. These are our metrics of the quality of our surgery. We as leaders should accept the responsibility. When a lobectomy or segmentectomy specimen is resected the surgeon has every opportunity to remove all of the lymph nodes that he or she might have included in that specimen on a back table and label them properly as described previously.

We have been using this technique since 1996. It is simple. It works. It completely prevents all of the problems articulated in the editorial. And you only need 1 pathologic slip for all of the lymph nodes from each station and then enumerate how many total lymph nodes that were removed from each station. If the surgeon truly believes there is value in en bloc resection for which we are unaware of any data to support, then they can simply dissect the packet out on the back table and send it to pathology properly labeled. The pathologist cannot determine where a 2R becomes a 4R. And they are not to blame for the poorly labeled surgical specimen. Leaders do not blame their teammates, instead they inspire others to perform better and take accountability.

The unfortunate and pervasive history of poorly performed and inadequately labeled lymph node dissection for patients with lung cancer has diminished the true value of lung cancer resection surgery compared with ablative therapies such as stereotactic radiosurgery, radiofrequency ablation, and now robotic bronchoscopic ablation of peripheral nodules.

Highly functional teams that provide their patients the best of care, which every patient deserves every day, is marked by great leaders. And even lymph nodes can teach us about leadership accountability and excellence.

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Reference

1. Kneuert PJ, Merritt RE. Lymph node stations counts in retrospective studies—important end point, but interpret with caution. *J Thorac Cardiovasc Surg.* 2020;159:e145.

<https://doi.org/10.1016/j.jtcvs.2019.09.005>

**REPLY FROM THE
AUTHORS: THE
QUANTIFICATION OF
NODAL DISEASE HAS
PROGNOSTIC
RELEVANCE**

Reply to the Editor:

The letter by Drs Kneuert and Merritt describing the limitations encountered in retrospective studies to count