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Commentary: Ground-glass opacity–dominant lung cancer. Is every R0 wedge resection always a good wedge resection?

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We have read with interest this article reporting the results of a multicenter trial aimed to define the role of sublobar resection in peripheral ground-glass opacity (GGO)-dominant lung cancer, which concluded that local disease control and recurrence-free survival are sufficient when surgical margin is enough.¹ Despite the fact that many studies have already been published with similar results, we strongly believe that the topic is still meaningful. Moreover, this is the first prospective study that addresses outcomes after sublobar resection for dominant GGOs, whereas all previous ones were retrospective. This increases the power of the study despite the fact that it is a single-arm trial without randomization and comparison with lobectomy. However, understandably, the authors excluded the possibility of a double-arm trial since few thoracic surgeons would have performed lobectomy for peripheral GGO-dominant lung cancer on thin-section computed tomography. Moreover, regardless of the need for even more conclusive results, wedge resections and segmentectomies are worldwide consolidated procedures in these patients. Therefore, in our opinion, the article does not influence the already widespread clinical practice concerning the use of sublobar resection but addresses 2 other meaningful points that are the real frontier in the

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CENTRAL MESSAGE

We have learned that sublobar resection with >5 mm margin for dominant GGOs is a successful strategy to replace lobectomy. Now the real point to clarify is what to do in case of R0 <5-mm margin?

management of peripheral dominant GGOs: nodes and margin.

Concerning node dissection, the authors could have better defined the criteria adopted to investigate microscopic nodal involvement when they report “intraoperative unresectable factors.” However, based on authoritative results of JCOG0201,² we agree that when radiologic features are consistent with noninvasive lung cancer, lymphadenectomy could be avoided since unexpected N1 or N2 disease is very uncommon.³

In regard to the second point, the authors have set their surgical strategy on margin and successfully introduced a 5-mm threshold, independently from tumor size. As such, they were able to demonstrate that wedge resection is effective if appropriate conversion to segmentectomy or lobectomy is done in case of macroscopic-positive or less than 5 mm margin. Their data are certainly reassuring in most of cases when a wide (more than 5 mm) margin is easy achievable; however, our concern regards cases with <5 mm distance between tumor and cut-end. Indeed, some authors have already showed that margins did not affect prognosis in R0 predominant GGO (even bigger than 2 cm) comparing 2 groups according to the margin width (resection margin ≤5 mm and resection margin >5 mm).⁴ Therefore, in our opinion, the key point is not the appropriateness of wide margin resections but,

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Disclosures: The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication Oct 5, 2020; revisions received Oct 5, 2020; accepted for publication Oct 6, 2020; available ahead of print Oct 13, 2020.

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J Thorac Cardiovasc Surg 2022;163:305-6

0022-5223/\$36.00

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<https://doi.org/10.1016/j.jtcvs.2020.10.023>

on the contrary, when conversion is really needed with R0 thin margin (<5 mm), considering that conversion to segmentectomy may require exposing patients to further surgical risks, often without even the possibility of having an intraoperative certainty of cancer.⁵ Lastly, while lobectomy and segmentectomy are anatomically highly standardized procedures regardless of the approach, wedge resection just removes a triangle-shaped slice of tissue without other established criteria than margin and is highly surgeon-dependent. Therefore, the question is as follows: in case of peripheral <2 cm dominant GGOs, is R0 wedge resection always a good wedge resection? The jury is still out.

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