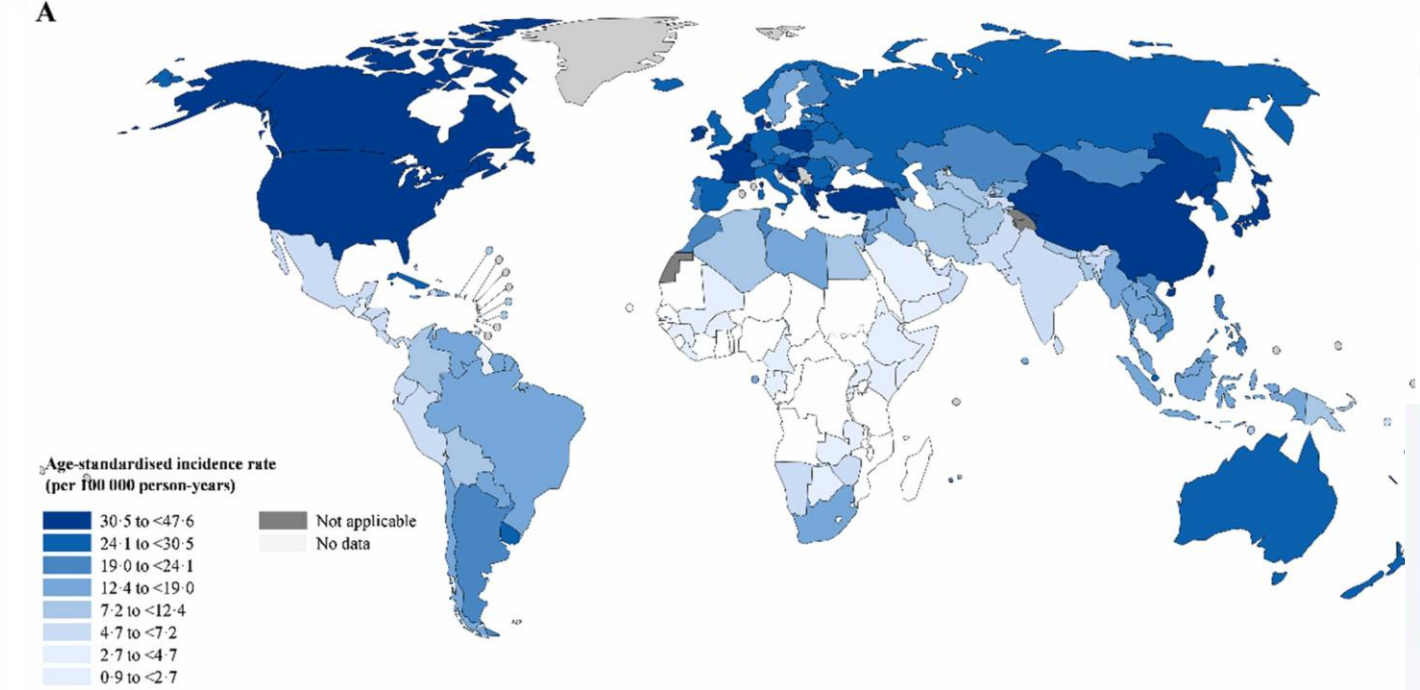
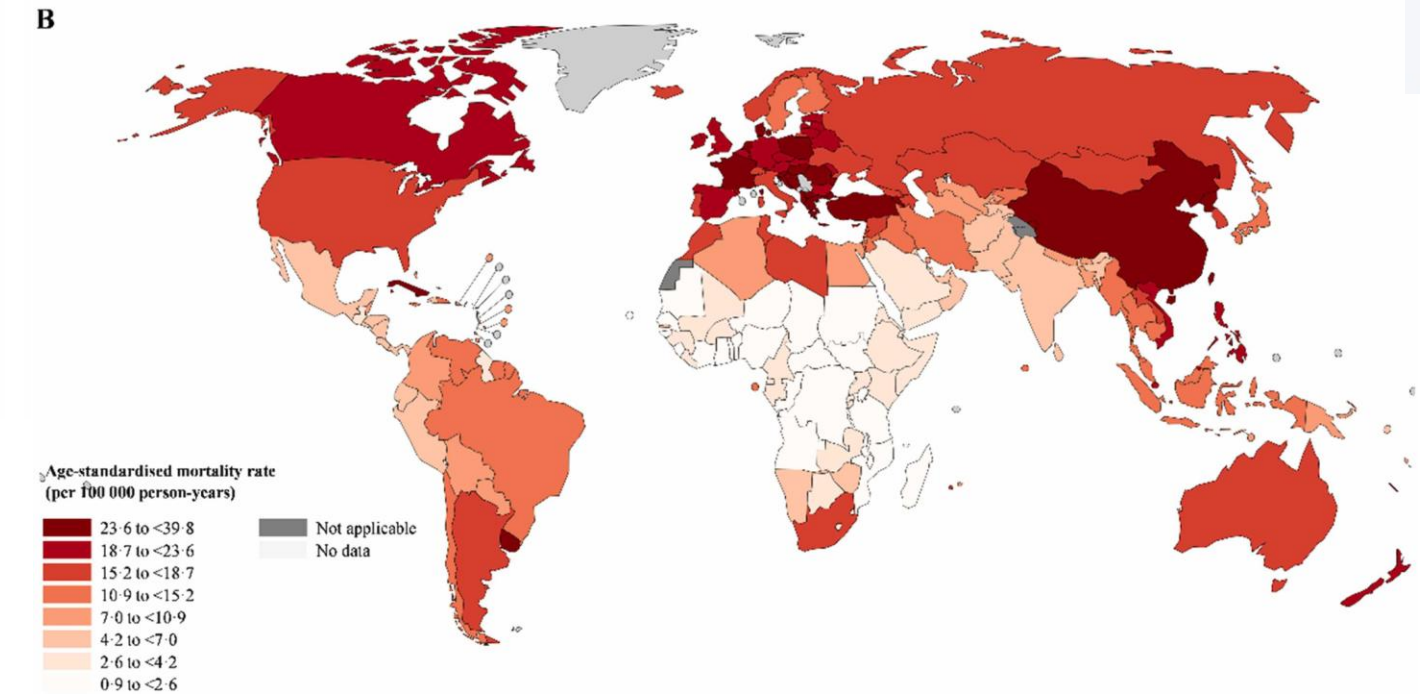
NGHIÊN CỨU MỐI LIÊN QUAN DI CĂN HẠCH VÀ ĐẶC ĐIỂM KHỐI U Ở BỆNH NHÂN UNG THƯ PHỔI KHÔNG TẾ BÀO NHỎ ĐƯỢC PHẪU THUẬT





International Agency for Research on Cancer
World Health Organization

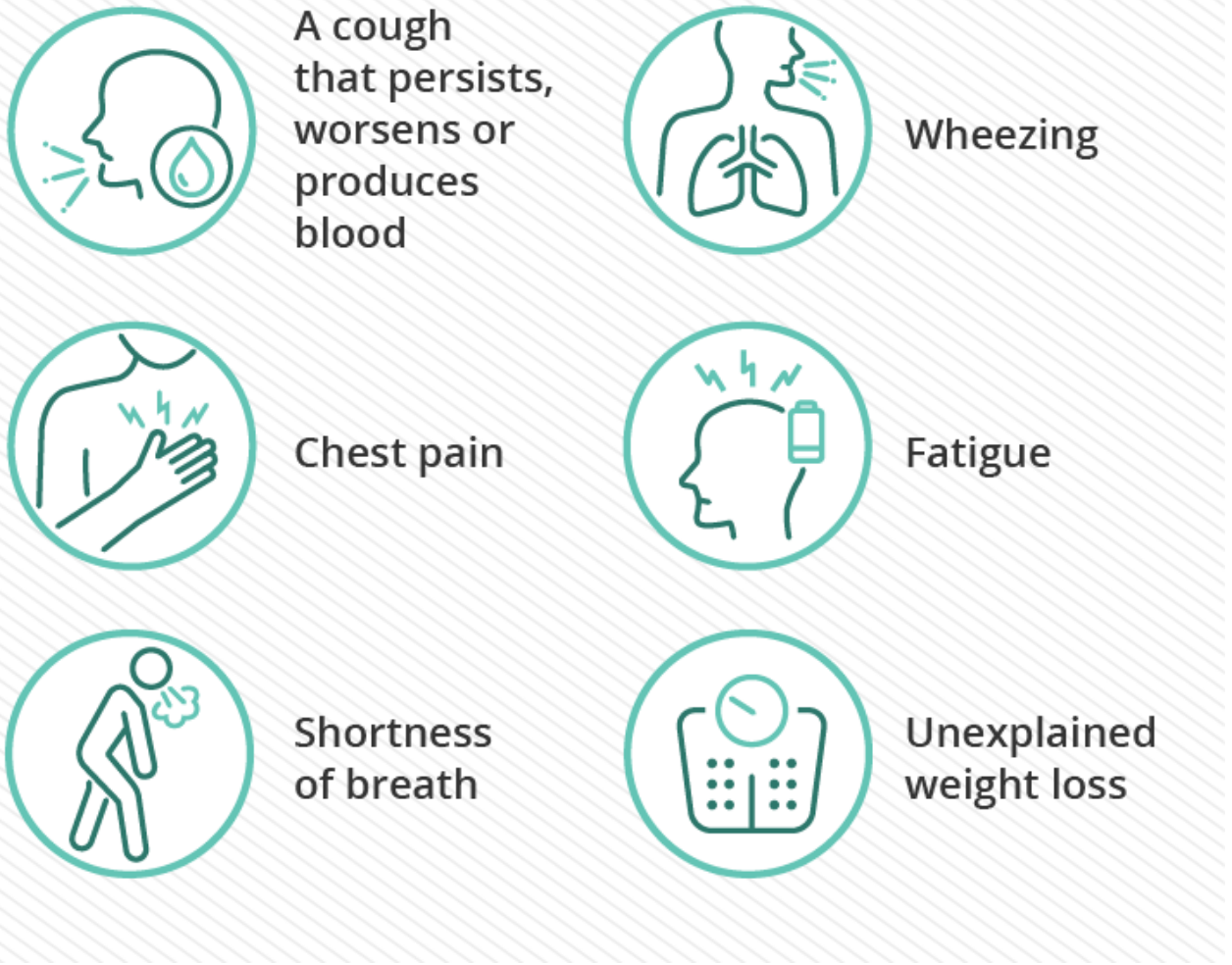
GLOBAL CANCER OBSERVATORY

CANCER TODAY
GLOBOCAN 2022

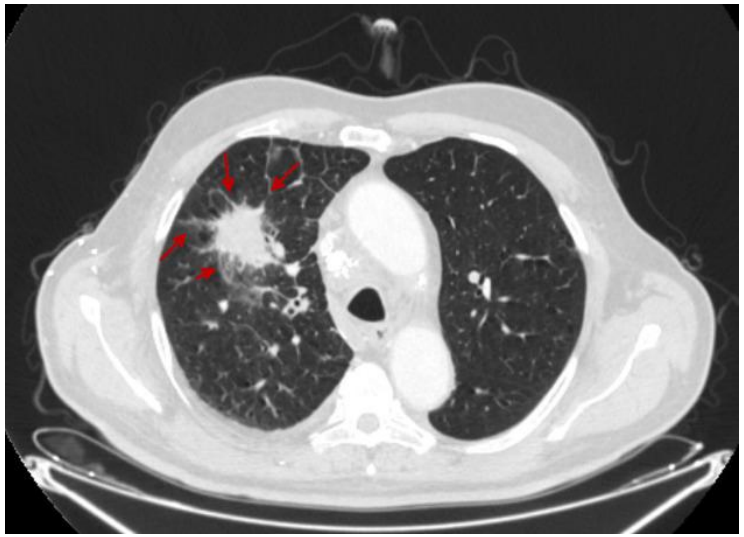
LUNG

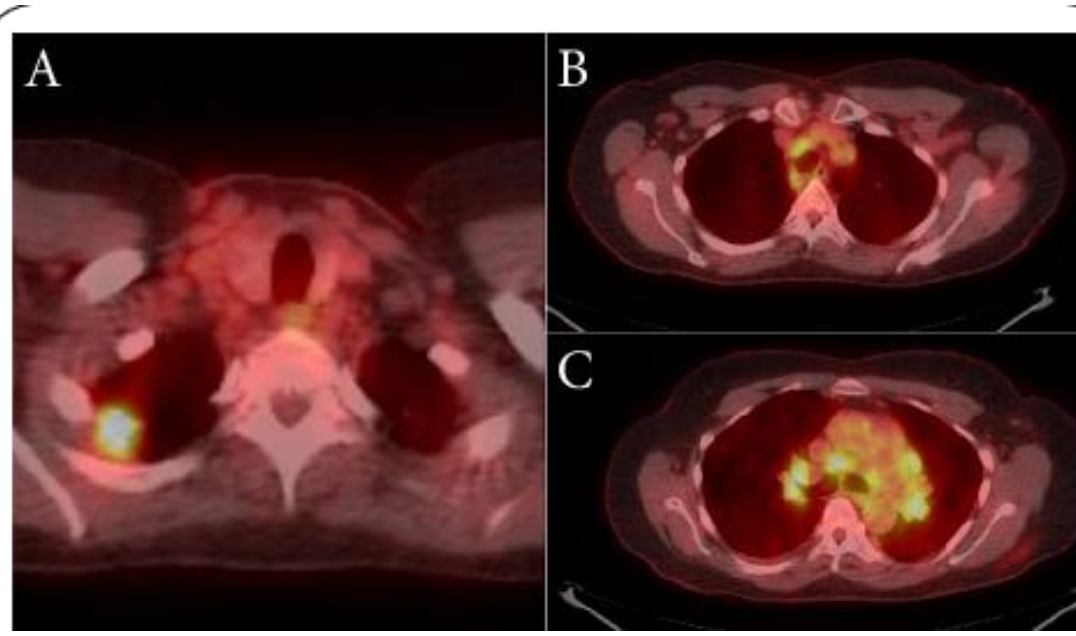
Incidence			Mortality		
Rank	Cases	ASR (World)	Rank	Deaths	ASR (World)
1	2 480 675	23.6	1	1 817 469	16.8

LÂM SÀNG


A cough that persists, worsens or produces blood
Wheezing
Chest pain
Fatigue
Shortness of breath
Unexplained weight loss

HÌNH ẢNH CHẨN ĐOÁN





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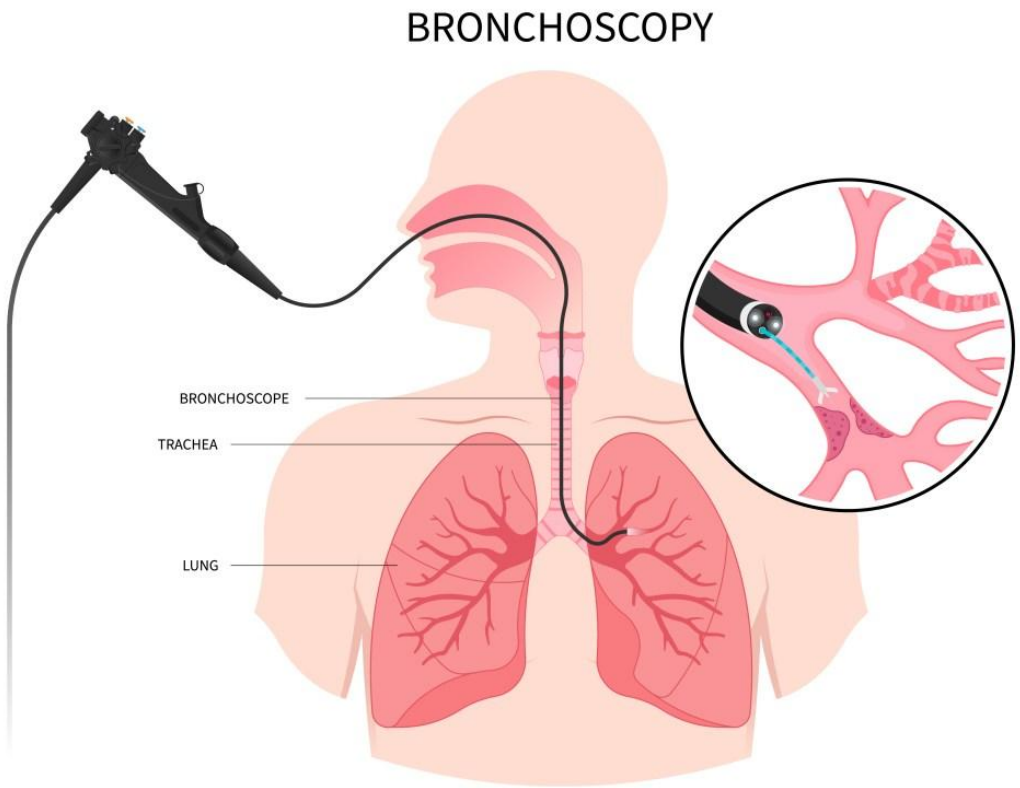
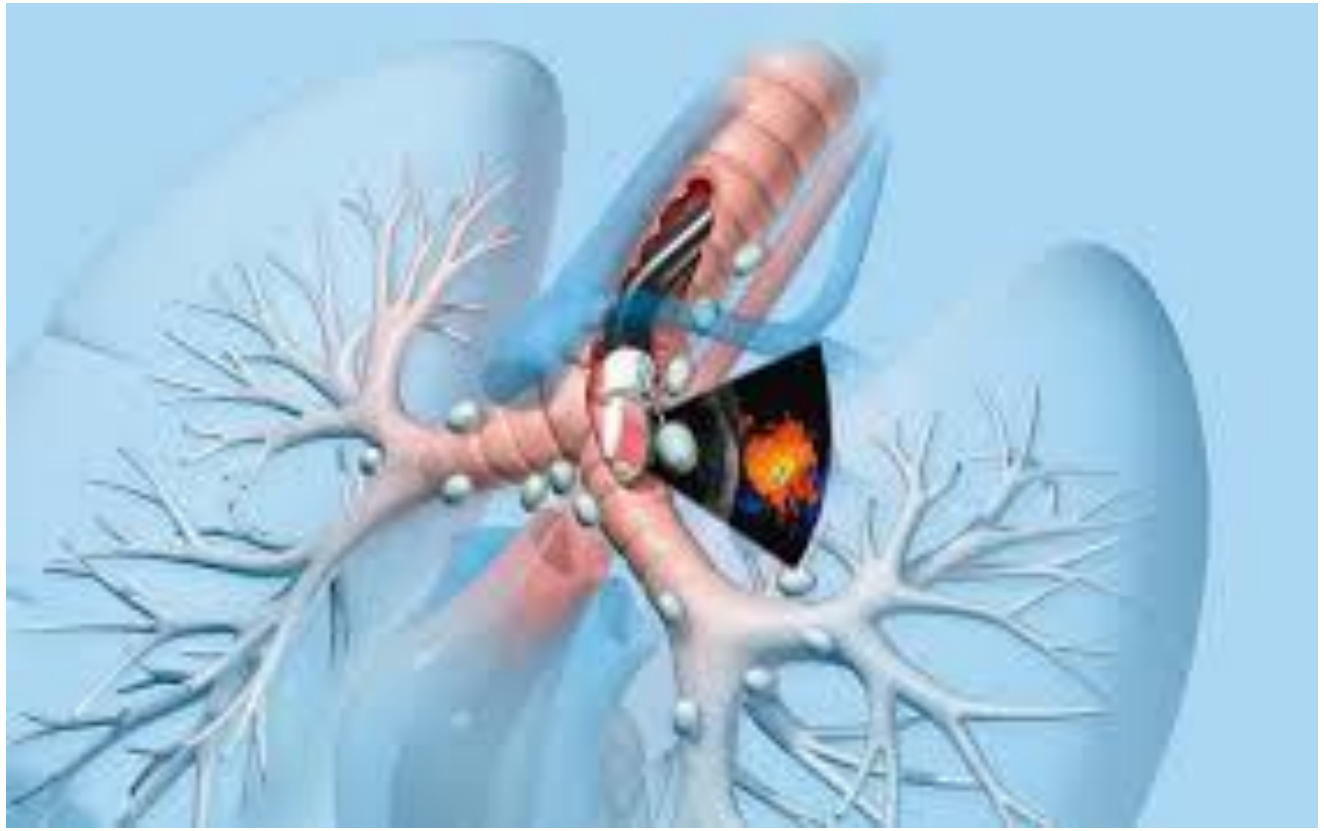


Nội soi phế quản

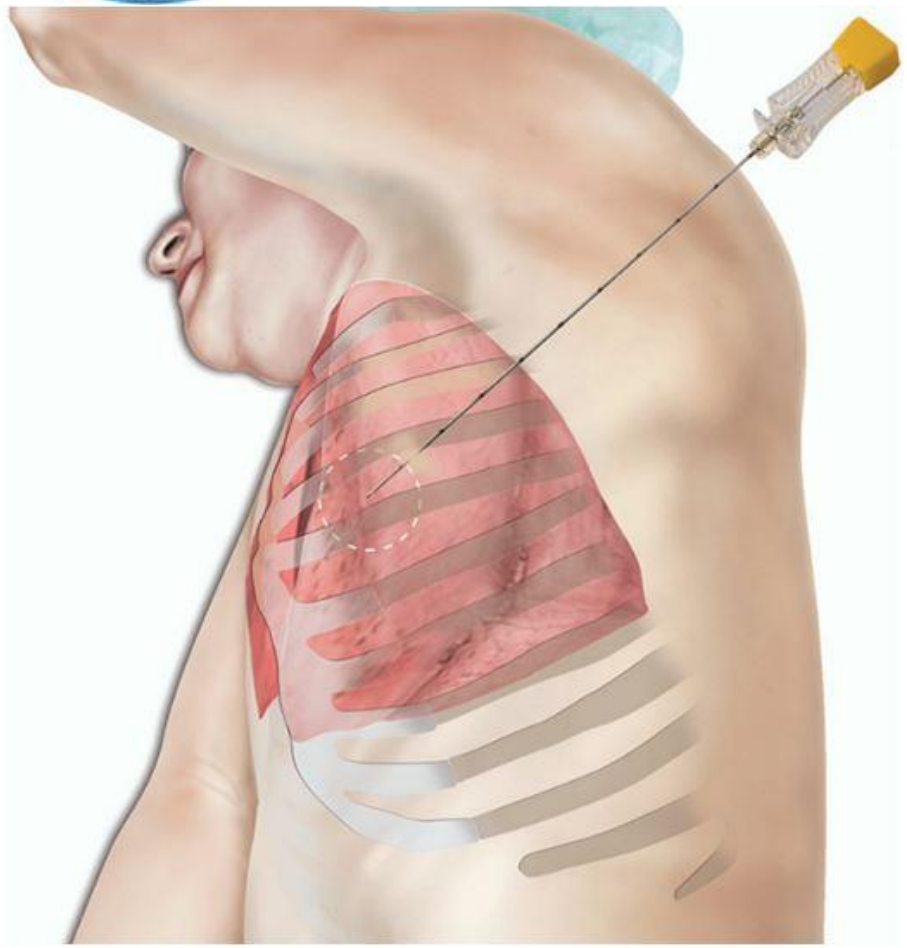
Thủ thuật thường quy trước phẫu thuật

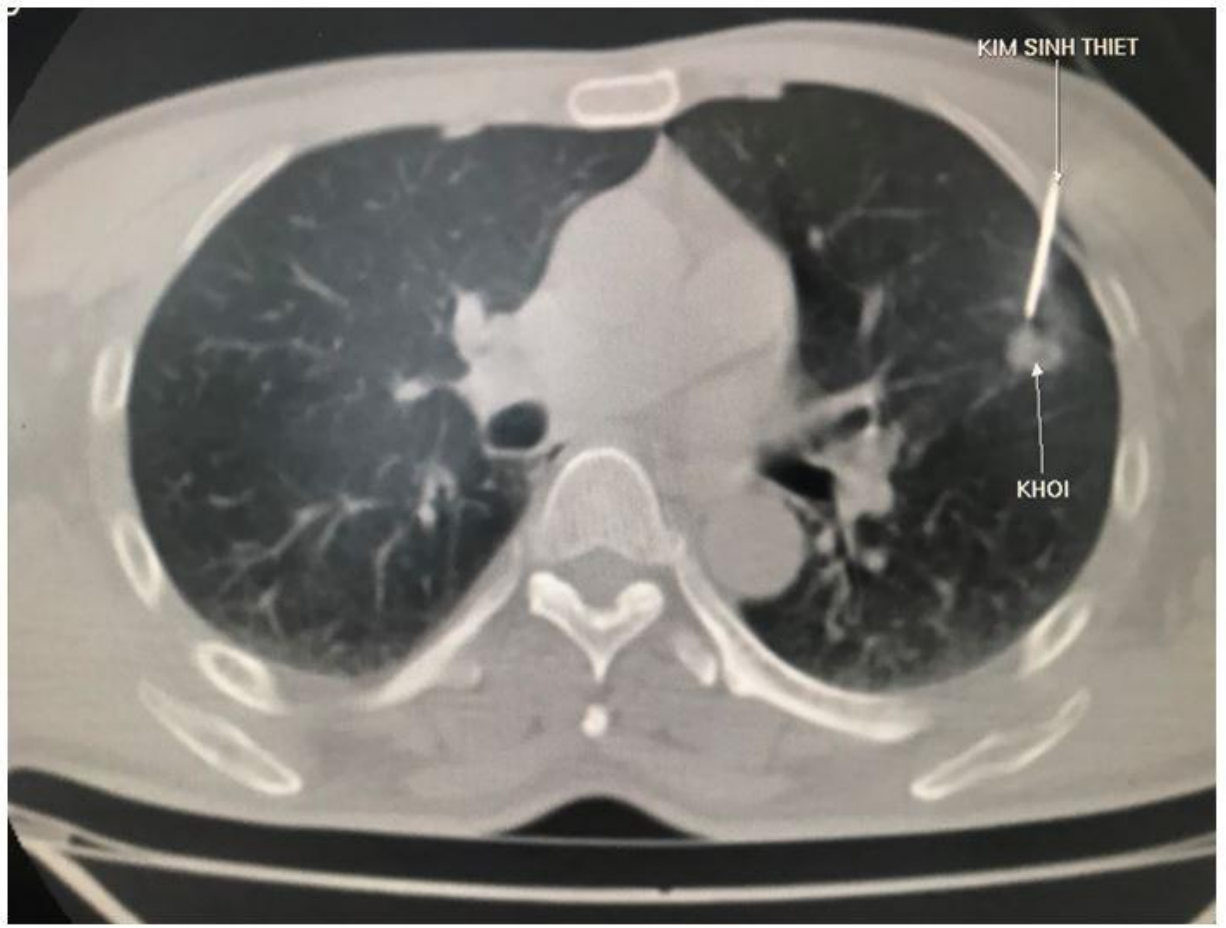
HÌNH ẢNH CHẨN ĐOÁN



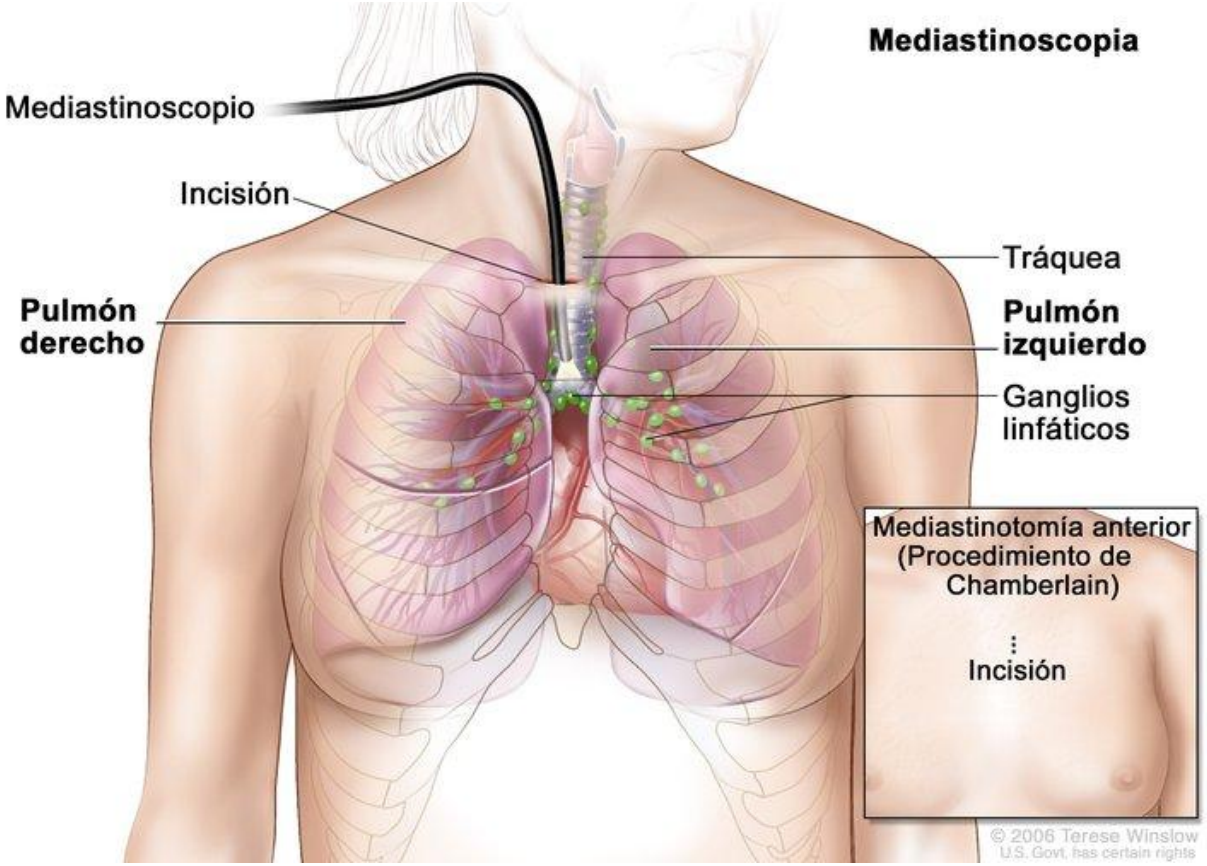
EBUS
EBUS - TBNA

CHẨN ĐOÁN MÔ BỆNH HỌC



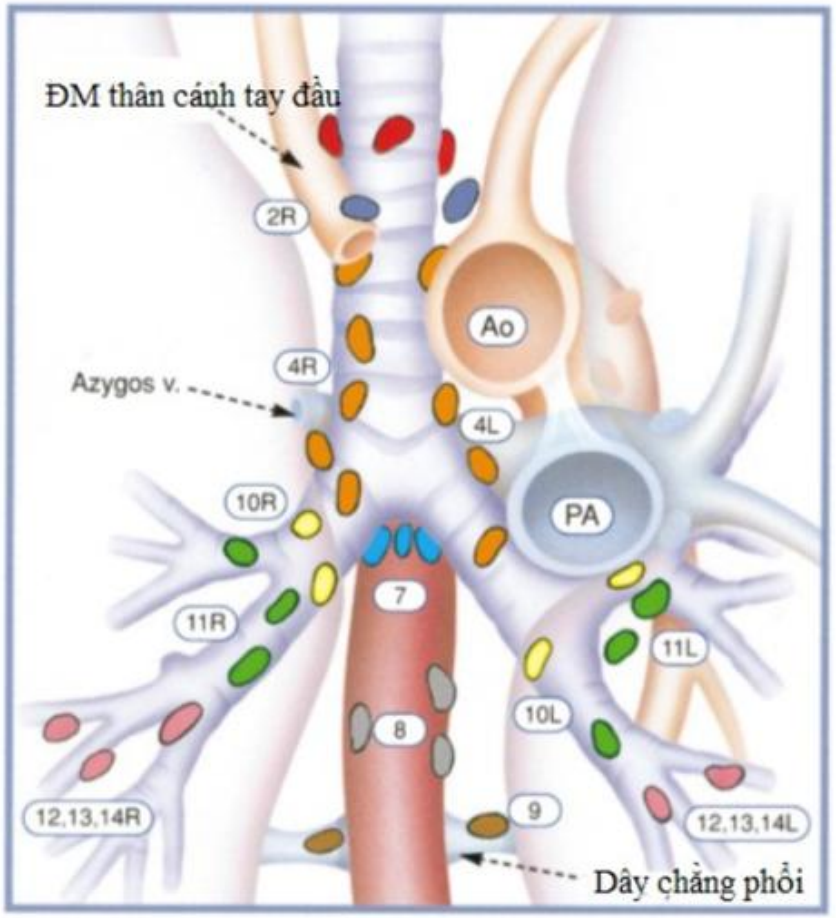


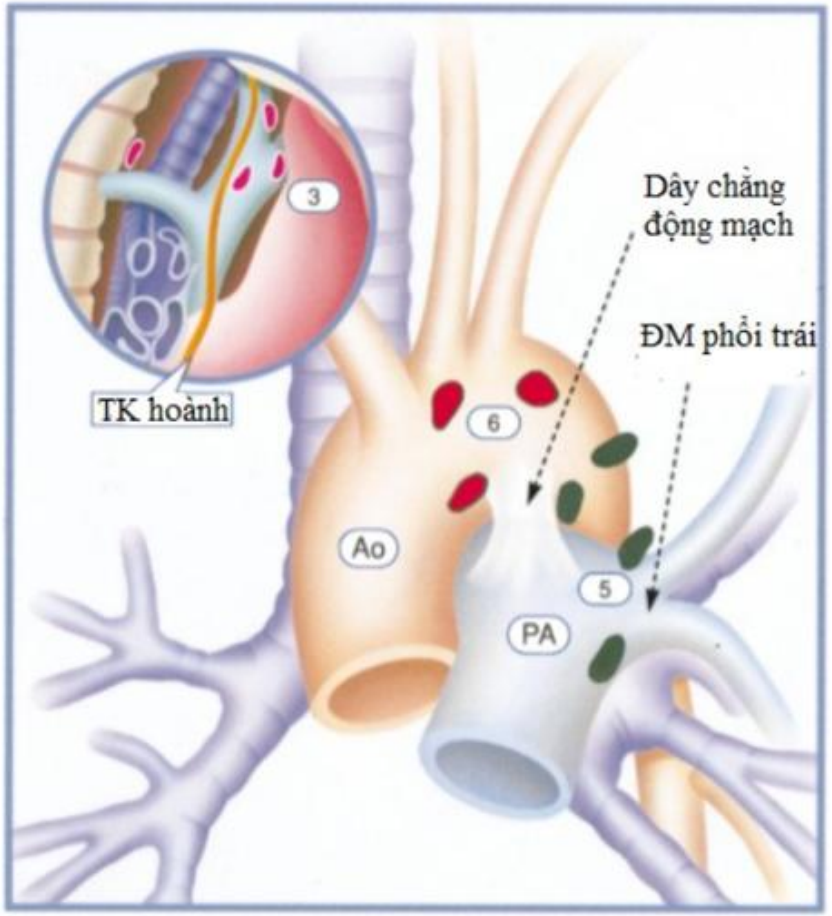
CHẨN ĐOÁN MÔ BỆNH HỌC



Nội soi trung thất

BẢN ĐỒ HẠCH


ĐM thân cánh tay đầu
2R
Ao
4R
Azygos v.
4L
10R
PA
7
11R
11L
10L
8
12,13,14R
9
12,13,14L
Dây chằng phổi


3
Dây chằng
động mạch
ĐM phổi trái
TK hoành
6
Ao
5
PA

ĐÁNH GIÁ GIAI ĐOẠN

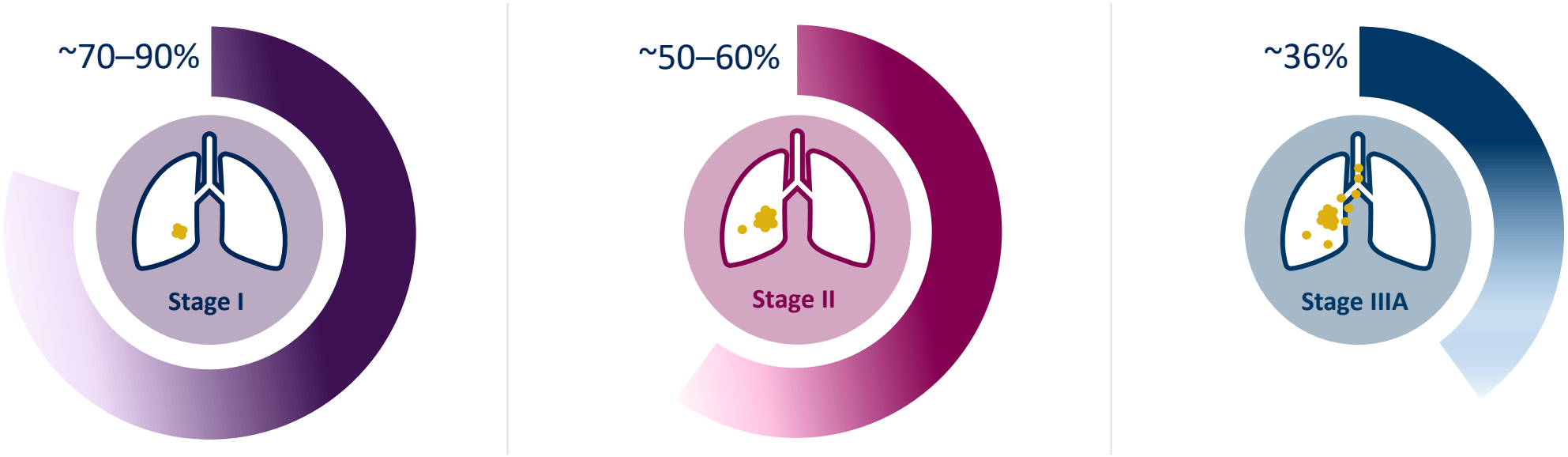
TABLE 5] Lung Cancer Stage Grouping (Eighth Edition)

T/M	Label	N0	N1	N2	N3
T1	T1a ≤1	IA1	IIB	IIIA	IIIB
	T1b >1-2	IA2	IIB	IIIA	IIIB
	T1c >2-3	IA3	IIB	IIIA	IIIB
T2	T2a *Cent, Visc Pl*	IB	IIB	IIIA	IIIB
	T2a >3-4	IB	IIB	IIIA	IIIB
	T2b >4-5	IIA	IIB	IIIA	IIIB
T3	T3 >5-7	IIB	IIIA	IIIB	IIIC
	T3 *Inv*	IIB	IIIA	IIIB	IIIC
	T3 *Satell*	IIB	IIIA	IIIB	IIIC
T4	T4 >7	IIIA	IIIA	IIIB	IIIC
	T4 *Inv*	IIIA	IIIA	IIIB	IIIC
	T4 *Ipsi Nod*	IIIA	IIIA	IIIB	IIIC
M1	M1a *Contr Nod*	IVA	IVA	IVA	IVA
	M1a *Pl Dissem*	IVA	IVA	IVA	IVA
	M1b *Single*	IVA	IVA	IVA	IVA
	M1c *Multi*	IVB	IVB	IVB	IVB

See Table 3 text and legend for expansion of abbreviations.

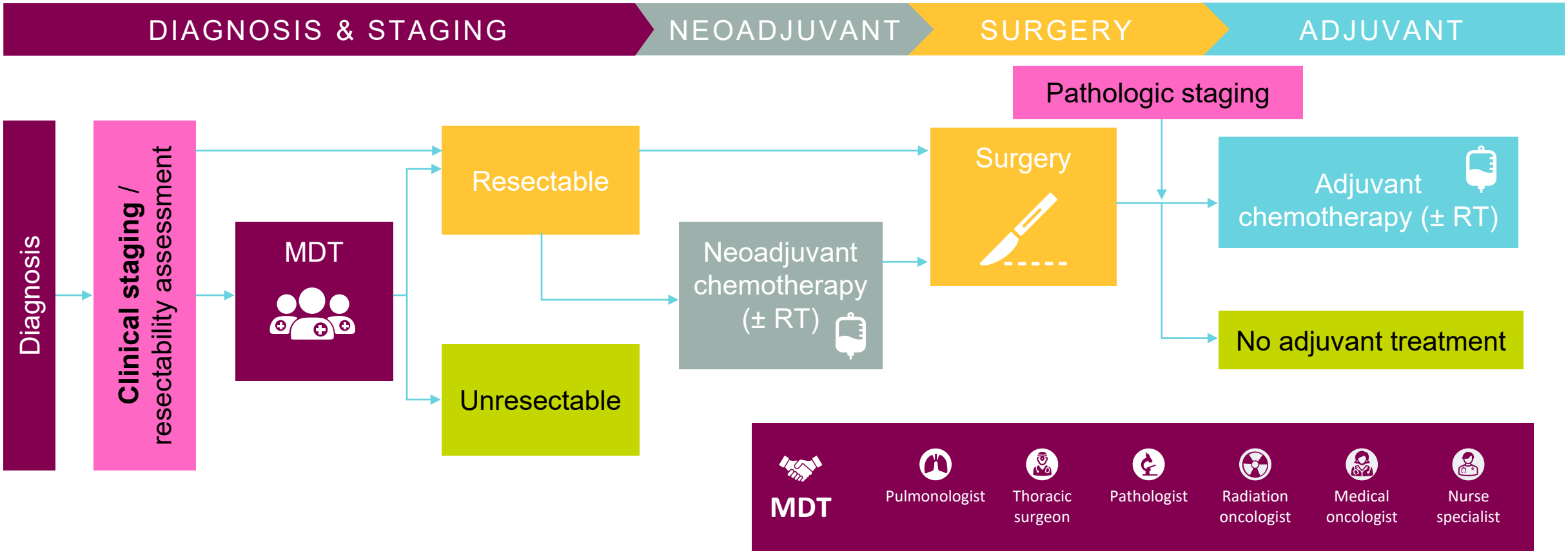
TỈ LỆ SỐNG CÒN 5 NĂM

Global 5-year OS* rates in patients with resectable NSCLC[7–9]



=> Chẩn đoán sớm ung thư phổi góp phần cải thiện tiên lượng bệnh nhân

ĐIỀU TRỊ



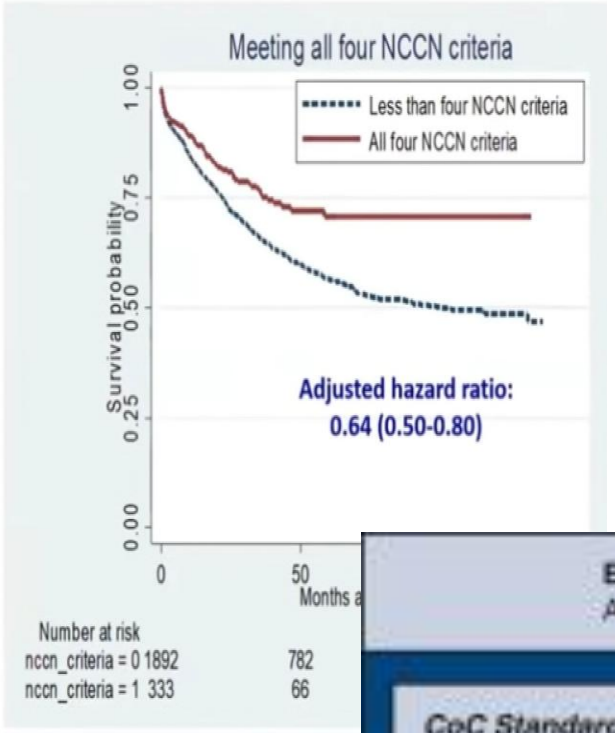
- MDT, multidisciplinary team; RT, radiotherapy
- Postmus PE, et al. Ann Oncol 2017;28(suppl 4):iv1–iv21; NCCN. NCCN Clinical Practice Guidelines in Oncology. Non-small cell lung cancer. Version 3.2020. https://www.nccn.org/store/login/login.aspx?ReturnURL=https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed April 2020

Examining Mediastinal Lymph Nodes Improves Survival

Following NCCN quality resection guidelines improves survival

NCCN Guidelines:

1. Anatomic resection
2. Negative margins
3. Examination of hilar/ intrapulmonary LNs
4. Examination of ≥3 mediastinal LNs



Osarogiagbon et al. 2017

facs.org/cssp

Cancer Surgery Standards PROGRAM

Early Compliance with Lung Cancer Lymph Node Standard 5.8:
An Analysis of 2022 and 2023 Commission on Cancer Site Reviews

CoC Standard 5.8: *Lymph node sampling from ≥ 3 mediastinal stations and ≥ 1 hilar station*

Study Aim: Evaluate hospital compliance with Standard 5.8 from recent CoC site visit data through a federally funded collaboration

CoC Site Review Data (2022-2023)

652 Hospitals with a site visit

↓

504 (75%) Hospitals with eligible cases

↓

272 (54%) Hospitals found compliant

JTCVS

Baskin et al., 2025 @AATSHQ

Ann Surg Oncol
https://doi.org/10.1245/s10434-018-6394-9

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – THORACIC ONCOLOGY

Incidence and Distribution of Lobe-Specific Mediastinal Lymph Node Metastasis in Non-small Cell Lung Cancer: Data from 4511 Resected Cases

Run-Bin Liang, MD[1,2,3], Jie Yang, MD[1,2,3], Tai-Shan Zeng, PhD[4], Hao Long, MD[1,2,3], Jian-Hua Fu, MD[1,2,3], Lan-Jun Zhang, MD[1,2,3], Peng Lin, MD[1,2,3], Xin Wang, MD[1,2,3], Tie-Hua Rong, MD[1,2,3], Xue Hou, MD[2,3,5], and Hao-Xian Yang, MD[1,2,3]

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[2]State Key Laboratory of Oncology in South China, Gu
Innovation Center for Cancer Medicine, Guangzhou City
South China Normal University, Guangzhou City, Guan
Yat-sen University Cancer Center, Guangzhou City, Gu

ABSTRACT

Objective. We aimed to investigate the incidence and distribution of mediastinal lymph node metastases (MLNM) in operable non-small cell lung cancer (NSCLC) with the purpose of guiding mediastinal lymph node dissection (MLND).

Methods. A total of 4511 NSCLC patients who underwent resection between January 2001 and December 2014 were included. These patients were preoperatively untreated and grouped according to the primary tumor lobes. The incidence and distribution of pathologic MLNM were compared among groups, and multivariate analysis was conducted to find the independent factors impacting MLNM.

Results. Lymph node involvement was observed in 1784 patients (39.5%). A total of 628 cases (13.9%) were N1-positive only, 752 cases (16.7%) were both N1- and N2-positive, and 404 cases (9.0%) were N2-positive only. The most common sites of mediastinal metastasis for different primary tumor lobes were the right upper lobe, station 4R (21.5%, 192/893); right middle lobe, station 7 (21.1%, 69/327); right lower lobe, station 7 (24.1%, 212/878); left upper lobe, station 5 (22.2%, 224/1008); and left lower lobe, station 7 (21.7%, 136/628). However, when only N2 cases were considered, each mediastinal lymph node zone can be involved with metastasis to a high proportion (> 5%). Multivariable analyses showed that poor cell differentiation, adenocarcinoma, larger tumor size, central type, and younger age were independent factors favoring MLNM.

Conclusions. Different primary tumor locations have a different propensity to be sites of MLNM; however, once MLNM occurs, each zone can be involved and should not be neglected. Systematic MLND is the preferred procedure for operable NSCLC.

Lymph node dissection (LND) is important for accurate

Original Article

Clinical significance of skipping mediastinal lymph node metastasis in N2 non-small cell lung cancer

Jun Zhao*, Jiagen Li*, Ning Li, Shugeng Gao

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Contributions: (I) Conception and design: J Zhao, S Gao; (II) Administrative support: Department of Thoracic Surgery, National Cancer Center/Cancer Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College; (III) Provision of study materials or patients: J Zhao, N Li; (IV) Collection and assembly of data: J Li, N Li; (V) Data analysis and interpretation: J Li, N Li; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

ıng cancer (NSCLC) patients, and understanding of the
N2 NSCLC patients without N1 lymph node involvement.

l in this study. Among them, 137 pN2 patients with no
ıer 666 patients [skip (−) group].

Results: The percentage of male, smoker and squamous cell carcinoma patients were significantly higher in the skip (+) group, (83.21% *vs.* 64.11%, P<0.001; 76.64% *vs.* 53.60%, P<0.001; 50.36% *vs.* 37.54%, P=0.007, respectively). Also, the primary tumor of skip (+) group patients were significantly more often located in the right upper and middle lobe (43.07% *vs.* 23.42%, 10.95% *vs.* 4.05%, P=0.001), and metastasis more frequently involved one lymph node station (75.18% *vs.* 49.55%, P<0.001). There was no significant difference in the number of total and N2 lymph node dissected. The postoperative survival of patients in both groups were also similar (P=0.379).

Conclusions: Skipping mediastinal lymph node metastasis happens in about 17% of NSCLC patients with mediastinal lymph nodes metastasis but it is not a prognostic factor.

European Journal of Cardio-Thoracic Surgery 56 (2019) 159–166
doi:10.1093/ejcts/ezy479 Advance Access publication 18 January 2019

ORIGINAL ARTICLE

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The incidence and distribution of mediastinal lymph node metastasis and its impact on survival in patients with non-small-cell lung cancers 3 cm or less: data from 2292 cases

Mu-Zi Yang[a,b,†], Xue Hou[b,c,†], Run-Bin Liang[a,b], Ren-Chun Lai[b,d], Jie Yang[a,b], Shuo Li[a,b], Hao Long[a,b], Jian-Hua Fu[a,b], Peng Lin[a,b], Xin Wang[a,b], Tie-Hua Rong[a,b] and Hao-Xian Yang[a,b,*]

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RESULTS: The most common mediastinal metastatic sites for different primary tumour lobes were as follows: right upper lobe, 17.7% (87/492) for level 4R; right middle lobe, 14.9% (28/188) for level 7; right lower lobe, 19.8% (82/414) for level 7; left upper lobe, 18.2% (96/528) for level 5; and left lower lobe, 16.6% (42/253) for level 7. For patients with tumours in the upper lobe, the median survival time was 32 months for those with MLNM in the subcarinal zone or lower zone compared with 83 months for those with MLNM only in the upper zone ($P < 0.01$). When the tumours were 1 cm or less, the incidence of MLNM to the lower zone for upper lobe tumours and of MLNM to the upper zone for lower lobe tumours was zero.

CONCLUSIONS: Different primary NSCLC lobe locations have a different propensity to be sites of MLNM for those tumours that are 3 cm or less. For tumours no larger than 1 cm, a lower zone mediastinal lymph node dissection might be unnecessary for upper lobe tumours and an upper zone mediastinal lymph node dissection might be unnecessary for lower lobe tumours.

Keywords: Non-small-cell lung cancer • Mediastinal lymph node • Surgery • Metastasis

KẾT LUẬN

- Ung thư phổi không tế bào nhỏ là ung thư có tỉ lệ mắc cũng như tỉ lệ tử vong cao nhất, cần chẩn đoán sớm và chẩn đoán giai đoạn chính xác cải thiện tiên lượng bệnh nhân
- Phẫu thuật nạo hạch theo tiêu chuẩn có thể cải thiện tiên lượng sống còn cho bệnh nhân
- Có mối liên quan giữa vị trí thuỳ phổi chứa u và nhóm hạch di căn cũng như kích thước khối u và di căn hạch

CẢM ƠN QUÝ THẦY CÔ
VÀ CÁC BẠN LẮNG NGHE