YUVARLAK MASA: Lokal İleri Evre KHDAK

Lokal İleri Evre KHDAK Hastalarında

Primer (Upfront) Cerrahi

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Göğüs Cerrahisi Anabilim Dalı

Çıkar çatışmam bulunmamaktadır…

Cerrahi Sonuçlar

Cerrahi Tipi	Operatif Mortalİte	Klinik Not
Wedge-Segmentektomi	%0,1-1	En düşük risk, parankim koruyucu
Lobektomi	%1	Standart tedavi (en sık, gold standard)
Sleeve rezeksiyon (bronşiyal / vasküler)	%1 – 2 (≈1.6)	Lobektomiye benzer, pnömonektomiden düşük
Pnömonektomi	%3 – 5	
Göğüs duvarı rezeksiyonu	%2-5	
Pankoast tm cerrahisi	< %3	
Karinal Sleeve rezeksiyon	%7-15	En yüksek mortalite
Vena Cava rezeksiyon	%10-12	

Rezeksiyon büyüklüğü arttıkça mortalite artar
Extended rezeksiyonlarda en yüksek

VATS vs Torakotomi

- Cerrahi travma ↓
  - inflamasyon ↓
  - stres yanıt↓
- Daha hızlı iyileşme
  - Hastanede kalış süresi ↓
  - Fonksiyonel toparlanma ↑
- Ağrı↓
  - Erken Mobilizasyon
- Pulmoner fonksiyon daha iyi korunur
  - kemoterapi toleransını artar

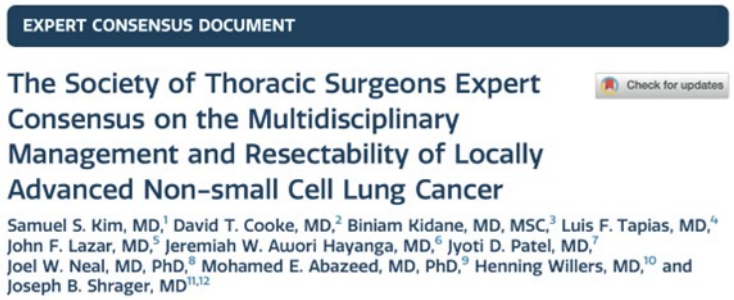
- VATS + Adjuvan KT
  - daha kolay tolere eder
  - KT daha erken başlanır
  - KT tamamlanma oranı ↑

- Boffa DJ et al.Getting patients to adjuvant therapy after lung cancer surgery.J Thorac Cardiovasc Surg. 2025.
- European Respiratory Society Study Group et al.Impact of surgical approach on adjuvant therapy delivery in NSCLC.Eur Respir J. 2024.
- Yang CJ et al.Minimally invasive surgery is associated with improved delivery of adjuvant chemotherapy after lung cancer resection.J Thorac Cardiovasc Surg. 2020.

Lokal İleri Evre Akciğer Kanseri

Evre II/IIIA–seçilmiş IIIB

- T3–T4
- N2 hastalık
  - tek vs multi-station



EXPERT CONSENSUS DOCUMENT

The Society of Thoracic Surgeons Expert Consensus on the Multidisciplinary Management and Resectability of Locally Advanced Non-small Cell Lung Cancer

Check for updates

Samuel S. Kim, MD,[1] David T. Cooke, MD,[2] Biniam Kidane, MD, MSC,[3] Luis F. Tapias, MD,[4] John F. Lazar, MD,[5] Jeremiah W. Awori Hayanga, MD,[6] Jyoti D. Patel, MD,[7] Joel W. Neal, MD, PhD,[8] Mohamed E. Abazeed, MD, PhD,[9] Henning Willers, MD,[10] and Joseph B. Shrager, MD[11,12]

IASLC

INTERNATIONAL ASSOCIATION FOR THE STUDY OF LUNG CANCER

Lung Cancer TNM Stages–9th Edition

Stage Groups of the 9th Edition of the Tumor, Node, Metastasis (TNM) Classification of Lung Cancer

9th Edition TNM Descriptors and Stages

T/M	Categories and Descriptors	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤1 cm	IA1	IIA	IIB	IIIA	IIIB
	T1b >1 to ≤2 cm	IA2	IIA	IIB	IIIA	IIIB
	T1c >2 to ≤3 cm	IA3	IIA	IIB	IIIA	IIIB
T2	T2a Visceral pleura / central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a >3 to ≤4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b >4 to ≤5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 >5 to ≤7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe separate tumor nodules	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 >7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invasion	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Ipsilateral separate tumor nodules	IIIA	IIIA	IIIB	IIIB	IIIC
M1	M1a Contralateral tumor nodules	IVA	IVA	IVA	IVA	IVA
	M1a Pleural / pericardial effusion, nodules	IVA	IVA	IVA	IVA	IVA
	M1b Single extrathoracic metastasis	IVA	IVA	IVA	IVA	IVA
	M1c1 Multiple metastases in 1 organ system	IVB	IVB	IVB	IVB	IVB
	M1c2 Multiple metastases in >1 organ systems	IVB	IVB	IVB	IVB	IVB

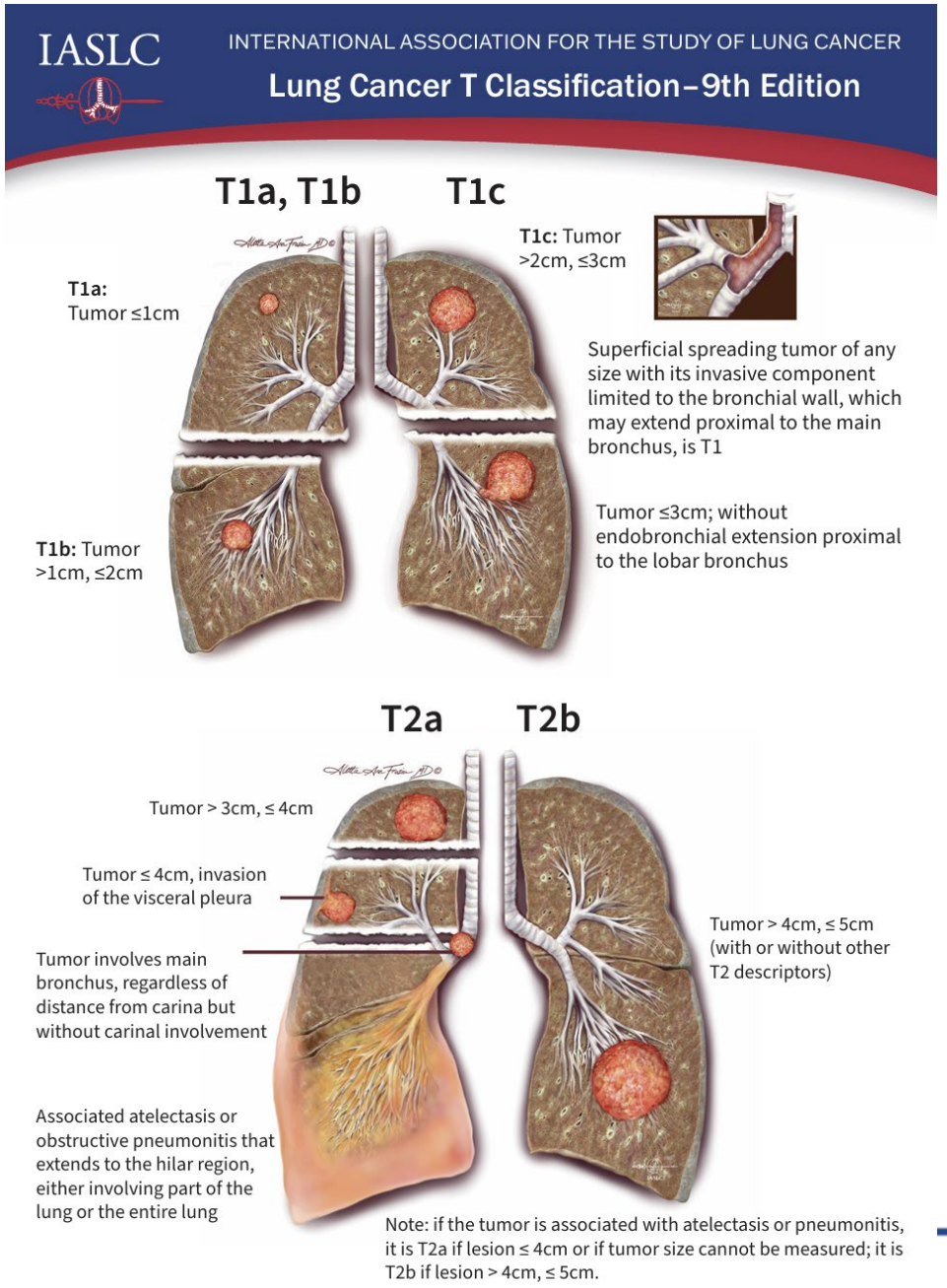
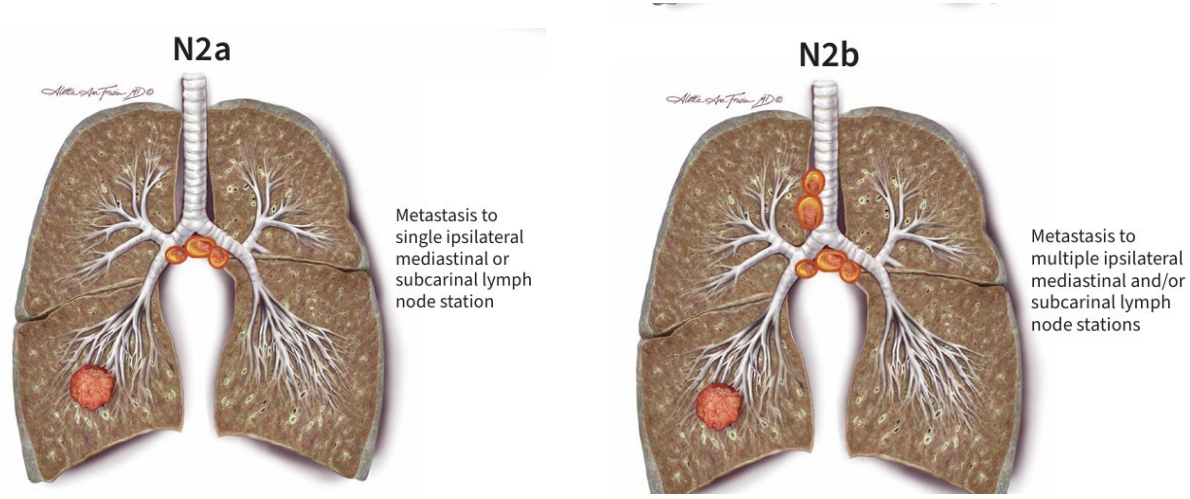


Figure. Courtesy of International Association for the Study of Lung Cancer. Permission must be requested and granted before

Heterojen hasta grubu

- VATS
  - Wedge-Segmentektomi
  - Lobektomi



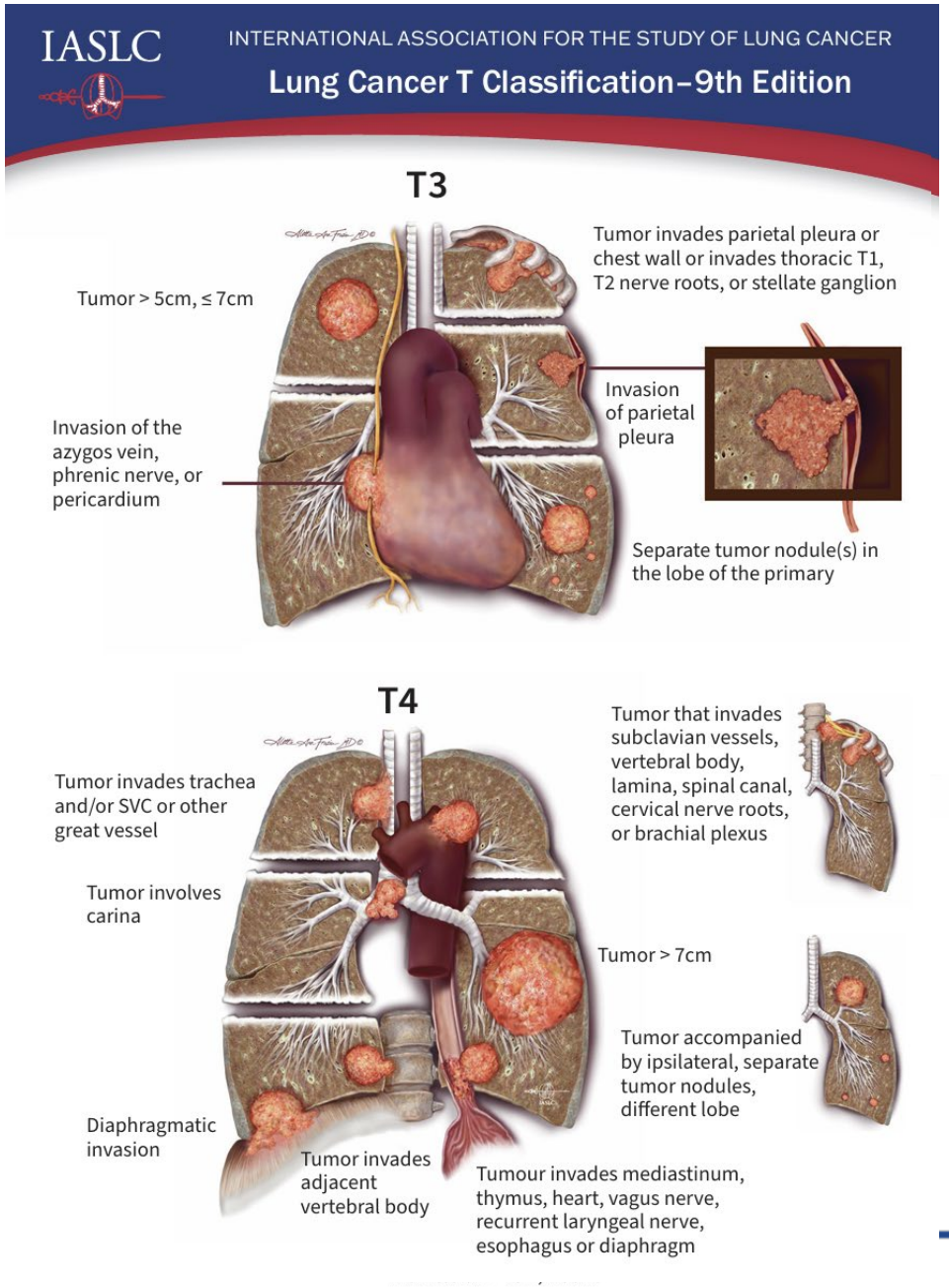
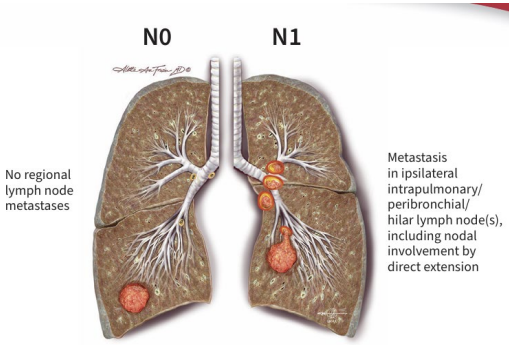
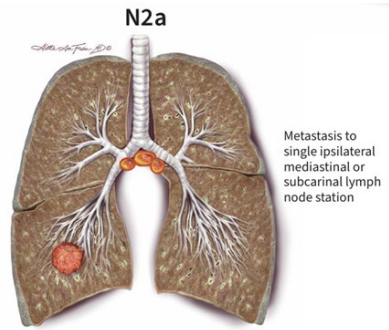


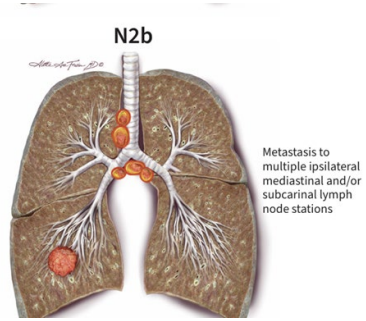
Figure. Courtesy of International Association for the Study of Lung Cancer. Permission must be requested and granted before

Heterojen hasta grubu

- Torakotomi
  - Lobektomi/Pnömonektomi
  - Ekstendet rezeksiyon







Lokal İleri Evre Akciğer Kanserinde Cerrahi

- Upfront cerrahi + Adj Tedavi
- Neoadjuvan tedavi + Cerrahi

Güncel Standart Yaklaşım

- Evre III hastalıkta -National Comprehensive Cancer Network (NCCN)
  -European Society for Medical Oncology (ESMO)
  -American Society of Clinical Oncology (ASCO)

genellikle multimodal tedavi

neoadjuvan kemoterapi ± immünoterapi ± RT + cerrahi

- İmmünoterapi çalışmaları -CheckMate 816
  -AEGEAN
  -KEYNOTE-671

neoadjuvan + cerrahi yaklaşım pTY ve sağkalım avantajı sağladığını göstermiştir

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Samuel S. Kim, MD,[1] David T. Cooke, MD,[2] Biniam Kidane, MD, MSC,[3] Luis F. Tapias, MD,[4]

TABLE 2 Consensus Summary of Surgical Resectability for Non-small Cell Lung Cancer[a]

			Nonbulky		Bulky	
Variable	**N0**	**N1**	**N2 Single**	**N2 Multstation**	**N2 Single**	**N2 Multistation**
T1/T2	Resectable	Resectable	Resectable	Potentially resectable	Potentially resectable	Unresectable
T3	Resectable	Resectable	Resectable	Potentially resectable	Potentially resectable	Unresectable
T3 (Pancoast)	Potentially resectable	Potentially resectable	Unresectable	Unresectable	Unresectable	Unresectable
T4 size	Potentially resectable	Potentially resectable	Unresectable	Unresectable	Unresectable	Unresectable
T4 satellite	Potentially resectable	Potentially resectable	Potentially resectable	Unresectable	Unresectable	Unresectable
T4 invasion	Potentially resectable	Potentially resectable	Unresectable	Unresectable	Unresectable	Unresectable

[a]This table represents a general recommendation for the surgical management of locally advanced lung cancer. Every case is unique, and in selected "unresectable" patients, surgical resection may be considered after a multidisciplinary discussion in the institutions with expertise.

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N1 hastalık:

- Klinik N1 hastalığı olanların önemli kısmı → pN2 (%30*)
- Tek N1 vs Multple N1 → multple N1 ile N2 sağkalımı benzer

→upfront cerrahi yerine neoadjuvan tedavi daha mantıklı bir yaklaşım olabilir

*Watanabe, Y., et al. Upfront surgery for clinical N1 stage II non-small cell lung cancer. Surg Today (2026).
**Noy J, et al. Outcomes of resectable locally advanced Non-Small cell lung cancer after neoadjuvant chemoimmunotherapy: a single institution experience. J Clin Med. 2025;14:988.
***Goto E, et al. Salvage extended surgery after immune-chekpoint inhibitor treatment for advanced non-small cell lung cancer. Surg Today. 2024;54:917–26.

Multidisipliner Onkoloji Konseyi

Cerrahi sonrası Adj oranı %60
Adj tedavinin katkısı yeterli mi?

- Onkoloji
  - **Kolay Tolere Edilir**
  - **İstenilen Doz ve Kür Sayısı**
  - **Erken Tedavi başlanır**

Daha İyi Tümör yanıtı

- Cerrahi
  - Rezektabilite artar
  - Pnömonektomi azalır
  - VATS artabilir?
  - Komplet rezeksiyon artar

- Sonuç
  - Mikrometastaz tedavisi
  - Kemosensitivite
  - Sağ Kalım Artabilir

Vakit Kazandırabilir (tıbbi, psikolojik ve sosyal hazırlık)

Solunum Rehabilitasyonu
Komorbidite regülasyonu
Beslenme desteği
Sigarayı bırakma
Ameliyata psikolojik hazırlık

Tartışma

Soru 1: Neoadjuvan sonrası pnömonektomi güvenli mi?

- Daha yüksek bronşiyal fistül riski
- Daha yüksek mortalite
  - Bazı serilerde Upfront pnömonektomi daha güvenli

Soru 2: Hilus diseksiyonu

- İmmünoterapi sonrası zor bir diseksiyon mu?
- Upfront cerrahi ile temiz bir diseksiyon mu?

Soru 3: Daha doğru mediastinal invaziv evreleme ve NT'de geçen zaman tedaviye geç başlamaya neden olabilir mi?

Tsai PC et al. J Chin Med Assoc. 2024 Feb 1;87(2):212-218.

Soru 4: Neoadjuvan tedavi sırasında progresyon? Cerrahi şansı kaybedilmesi-

- Neoadjuvan tedavi alan hastaların yaklaşık %20 si cerrahiye gidemez

Upfront Cerrahi- Avantajları

- ✓ Erken tümör kontrolü
- ✓ Doğru patolojik evreleme
  doğru tedavi
- ✓ Gereksiz tedaviden kaçınma
- ✓ Daha kolay cerrahi
- ✓ Daha düşük komplikasyon riski

OXFORD

BJS Open, 2024, zrae008
https://doi.org/10.1093/bjsopen/zrae008
Original Article

Upfront surgery for stage IIIA/B non-small cell lung cancer: retrospective cohort study

Hongsheng Deng[1,†], Jun Liu[1,†], Xiuyu Cai[2,†], Shunjun Jiang[1,3,†], Weixiang Lu[1], Qing Ai[1], Jianfu Li[1], Shan Xiong[1], Xiangyun Qin[4], Wenhua Liang[1,*] and Jianxing He[1,*]

- 1 Ocak 2012-31 Aralık 2019- Guangzhou Tıp Üniversitesi
- Evre cIIIA/B KHDAK Upfront cerrahi retrospektif
- Dahil edilme kriterleri
  - neoadjuvan tedavi almamış
  - cerrahi rezeksiyon (W, S, L, P, EksL)
- Hariç tutulma kriterleri
  - tanı anında başka malignitesi
  - Eksik veri

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- 664 hasta, 320'si (%48,8) N2
- %61 Adenokarsinom
- Lobektomi %85
- Pnömonektomi oranı %4,5
- T1-T2 → %70
- R1-R2 rezeksiyon → %6

Table 1 Baseline characteristics and surgical/pathological outcomes of included stage III patients ($n = 664$)

Variable	Value
Sex	
Male	410 (65.71)
Female	214 (34.29)
Age (years), mean(s.d.)	58.8(9.94)
<65	440 (70.51)
≥65	184 (29.49)
BMI (kg/m^2), mean(s.d.)	23.12(3.061)
Race, Chinese, %	100.0
Smoking history*	
Current/past	160 (29.04)/112 (20.33)
Never	279 (50.64)
Histological subtype	
LUAD	382 (61.22)
LUSQ	128 (20.51)
Other	114 (18.27)
cT status	
T1	225 (33.89)
T2	250 (37.65)
T3–T4	189 (28.46)
Maximum tumour diameter (cm)	

Table 2 Perioperative outcomes of all included patients ($n = 664$)

Variable	Value
Surgical procedure	
Pneumonectomy	30 (4.5)
Lobectomy	564 (84.9)
Sleeve lobectomy	48 (7.2)
Segmentectomy	5 (0.8)
Wedge resection	17 (2.6)
Surgical margin	
R0	624 (94.0)
R1	10 (1.5)
R2	30 (4.5)
pN status (based on surgical specimens)	
N0	51 (7.68)
N1	69 (10.39)
N2	521 (78.46)
Single-station metastasis	278 (53.35)
Multi-station metastasis	243 (46.64)
N3	23 (3.46)
pTNM stage	
IIIA	569 (91.19)
IIIB	55 (8.81)
IIIC	0

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- Mortalite %1,4
- Adjuvan tedavi %71
- Recürrens %37

5 yıllık sağkalım %49

Table 3 Postoperative outcomes of all included patients ($n = 664$)

Variable	Value
Adjuvant therapy	473 (71.23)
Chemotherapy	330 (49.70)
Targeted therapy	65 (9.79)
Chemotherapy + anti-angiogenic therapy	24 (3.61)
Chemotherapy + radiotherapy	23 (3.46)
Chemotherapy + targeted therapy	8 (1.20)
Other	23 (3.46)
Recurrence rate at the last follow-up time	247 (37.20)
Recurrence site (for all patients with recurrence)	
Lung	111 (50.45)
Brain	55 (25.00)
Skeleton	43 (19.54)
Liver	19 (8.64)
Lymph node	15 (6.82)
Other	41 (18.64)

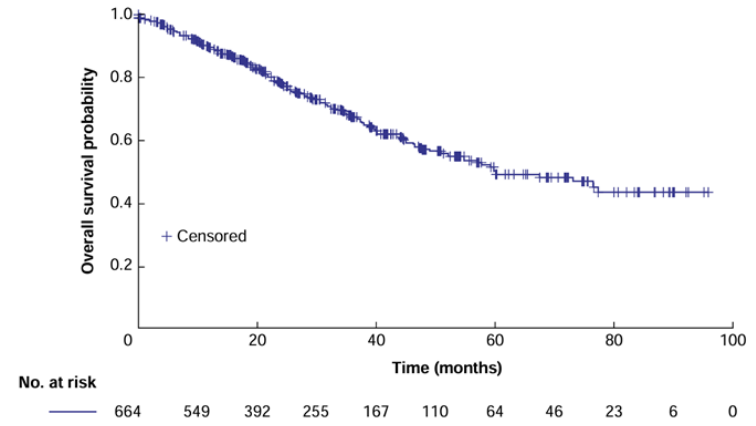

Fig. 1 Kaplan–Meier curve of overall survival for the included patients

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Table 4 Multivariable Cox analyses for recurrence-free survival and overall survival of included patients

	Recurrence-free survival		Overall survival	
	HR (95% c.i.)	*P*	HR (95% c.i.)	*P*
Age (reference = <65 years)		0.1308		0.0174
≥65 years	1.230 (0.940,1.608)		1.508 (1.075,2.115)	
Sex (reference = female)		0.8596		0.6176
Male	0.970 (0.695,1.354)		1.120 (0.718,1.748)	
Smoking status (reference = never a smoker)		0.6545		0.9865
Past smoker	1.039 (0.717,1.505)		0.987 (0.621,1.569)	
Current smoker	1.156 (0.830,1.611)		0.966 (0.630,1.482)	
Histology (reference = LUAD)		0.0577		0.1625
LUSQ	0.736 (0.533,1.017)		1.156 (0.789,1.692)	
LASC	1.109 (0.525,2.345)		1.446 (0.600,3.486)	
Other	0.641 (0.434,0.948)		0.594 (0.337,1.046)	
Tumour size (reference = <3 cm)		0.0016		0.0003
≥3 cm but <5 cm	1.136 (0.855,1.510)		1.153 (0.778,1.707)	
≥5 cm	1.723 (1.258,2.358)		2.130 (1.413,3.209)	
Surgical procedure (reference = pneumonectomy)		0.4444	–	0.5678
Segmentectomy	0.274 (0.036,2.117)			
Sleeve lobectomy	0.738 (0.356,1.534)		1.108 (0.438,2.804)	
Wedge resection	1.186 (0.522,2.694)		2.247 (0.779,6.484)	
Lobectomy	0.950 (0.526,1.718)		1.277 (0.574,2.840)	
Surgical margin (reference = R1/R2 resection)		0.4907		0.2163
R0 resection	0.834 (0.499,1.396)		0.684 (0.375,1.249)	
pN status (reference = pN0)		0.2175		0.5473
pN1	0.854 (0.484,1.506)		1.203 (0.590,2.454)	
pN2	1.121 (0.706,1.777)		1.450 (0.778,2.706)	
pN3	1.820 (0.874,3.787)		1.832 (0.721,4.659)	
Adjuvant treatment (reference = none)		0.0835		0.0163
Chemotherapy	0.797 (0.612,1.040)		0.686 (0.492,0.959)	
Targeted therapy	0.512 (0.296,0.887)		0.297 (0.117,0.756)	
Other	0.854 (0.576,1.265)		0.599 (0.356,1.009)	

LUAD, lung adenocarcinoma; LUSQ, lung squamous cell carcinoma; LASC, lung adenosquamous carcinoma; R0, R0 resection with negative margin; R1, R1 resection with microscopically positive margins; R2, R2 resection with macroscopically positive margins.

Sonuç: cerrahi, evre IIIA/B küçük hücre dışı akciğer kanserinin yönetimi için bir seçenektir.

European Journal of Cardio-Thoracic Surgery 58 (2020) 59–69
doi:10.1093/ejcts/ezaa042 Advance Access publication 10 March 2020

ORIGINAL ARTICLE

Cite this article as: Yun JK, Bok JS, Lee GD, Kim HR, Kim Y-H, Kim DK *et al.* Long-term outcomes of upfront surgery in patients with resectable pathological N2 non-small-cell lung cancer. Eur J Cardiothorac Surg 2020;58:59–69.

Long-term outcomes of upfront surgery in patients with resectable pathological N2 non-small-cell lung cancer

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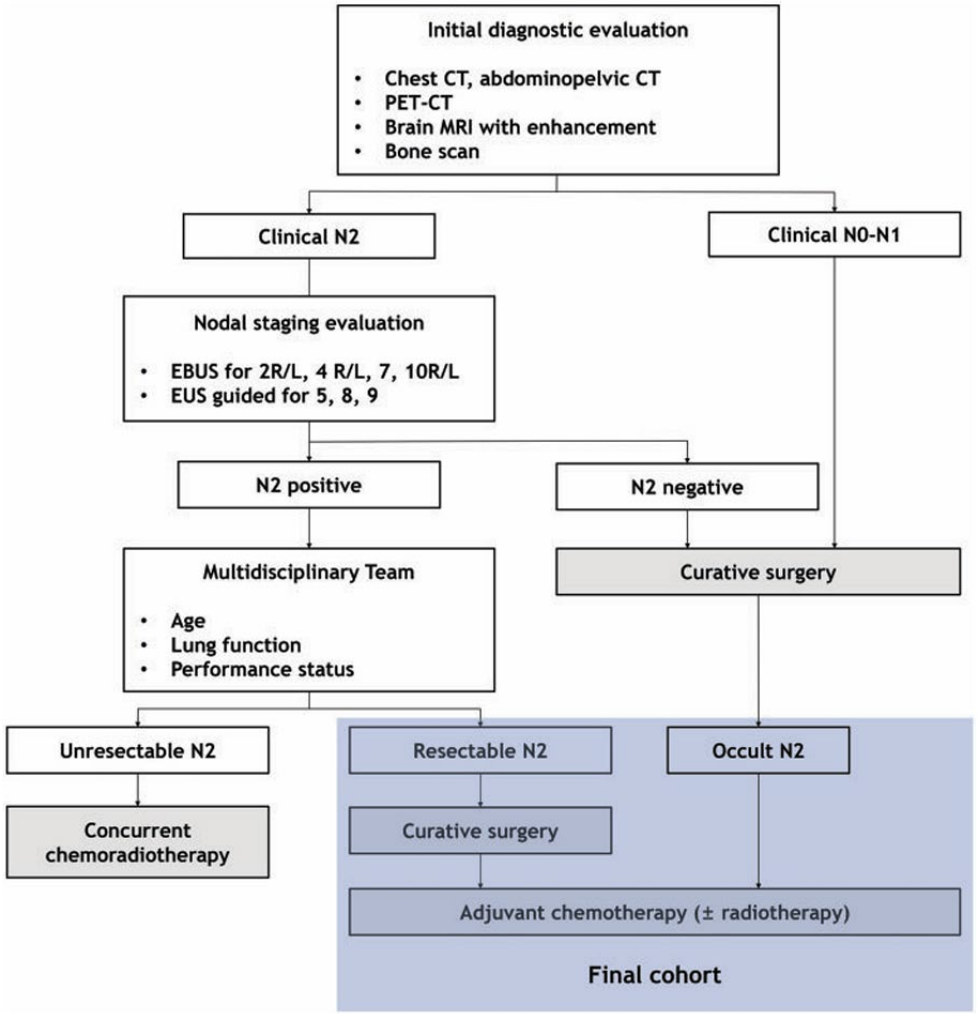

cN2- upfront cerrahi aday seçimi

Biyopsi ile kanıtlanmış cN2 varlığında

- Lobektomi ile operable
- tek zon (1–4, 5-6, 7, 8-9)
- 3 cm küçük ve ekstranodal yayılım yok

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Table 1: Characteristics of pN2 non-small-cell lung cancer patients who underwent upfront surgery ($N = 706$)

Variables		Variables	
Age (years), median (IQR)	62 (54–69)	Pathological tumour size (mm), median (IQR)	35 (25–48)
Sex, *n* (%)		Bulky lymph node (>30 mm), *n* (%)	37 (5.2)
Male	450 (63.7)	Surgical approach, *n* (%)	
Female	256 (36.3)	VATS	257 (36.4)
Smoking status, *n* (%)		Thoracotomy conversion	42 (5.9)
Smoker	425 (60.2)	Thoracotomy	407 (57.6)
Never-smoker	281 (39.8)	Operative method, *n* (%)	
Comorbidities per patient (*n*), *n* (%)		Lobectomy	602 (85.3)
0	360 (51.0)	Bilobectomy	53 (7.5)
1	226 (32.0)	Pneumonectomy	51 (7.2)
2	105 (14.9)	Number of resected lymph nodes, median (IQR)	
3	15 (2.1)	cN0	27 (21–34)
Pulmonary function test, *n* (%)		cN1	29 (22–38)
FEV1 (≤60%)	24 (3.4)	cN2	28 (23–36)
FEV1 (>60% and ≤80%)	155 (22.2)	Extra-nodal invasion, *n* (%)	246 (34.8)
FEV1 (>80%)	519 (74.4)	Pathological tumour factor (8th edition), *n* (%)	
Histological structure, *n* (%)		pT1	163 (23.1)
Adenocarcinoma	489 (69.3)	pT2	331 (46.9)
Squamous cell carcinoma	171 (24.2)	pT3	132 (18.7)
Others	46 (6.5)	pT4	80 (11.3)
Clinical T factor (8th edition), *n* (%)		Pathological N factor (8th edition), *n* (%)	
cT1	204 (28.9)	pN2a1	154 (21.8)
cT2	347 (49.2)	pN2a2	273 (38.7)
cT3	99 (14.0)	pN2b	279 (39.5)
cT4	56 (7.9)	Pathological stage (8th edition), *n* (%)	
Clinical N factor (8th edition), *n* (%)		IIIA	494 (70.0)
cN0	308 (43.6)	IIIB	212 (30.0)
cN1	123 (17.4)	Adjuvant therapy, *n* (%)	
cN2	275 (39.0)	Chemoradiotherapy	299 (42.4)
cN2a1	140 (19.8)	Chemotherapy alone	169 (23.9)
cN2a2	80 (11.3)	Radiotherapy alone	115 (16.3)
cN2b	55 (7.8)	None	123 (17.4)

FEV1: forced expiratory volume1; IQR: interquartile range; VATS: video-assisted thoracic surgery.

- cN0 →308 (%43,6)
- cN1 →123 (%17,4)
- **cN2 → 275 (%39)**

706 pN2

- R0 %90
- **%22 T3-T4**
- Lobektomi %85
- Pnömonektomi %7

KT →169 (%24)

RT →115 (%17)

KTRT →299 patients (%42)

Alamamış → %17

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ORIGINAL ARTICLE

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Long-term outcomes of upfront surgery in patients with resectable pathological N2 non-small-cell lung cancer

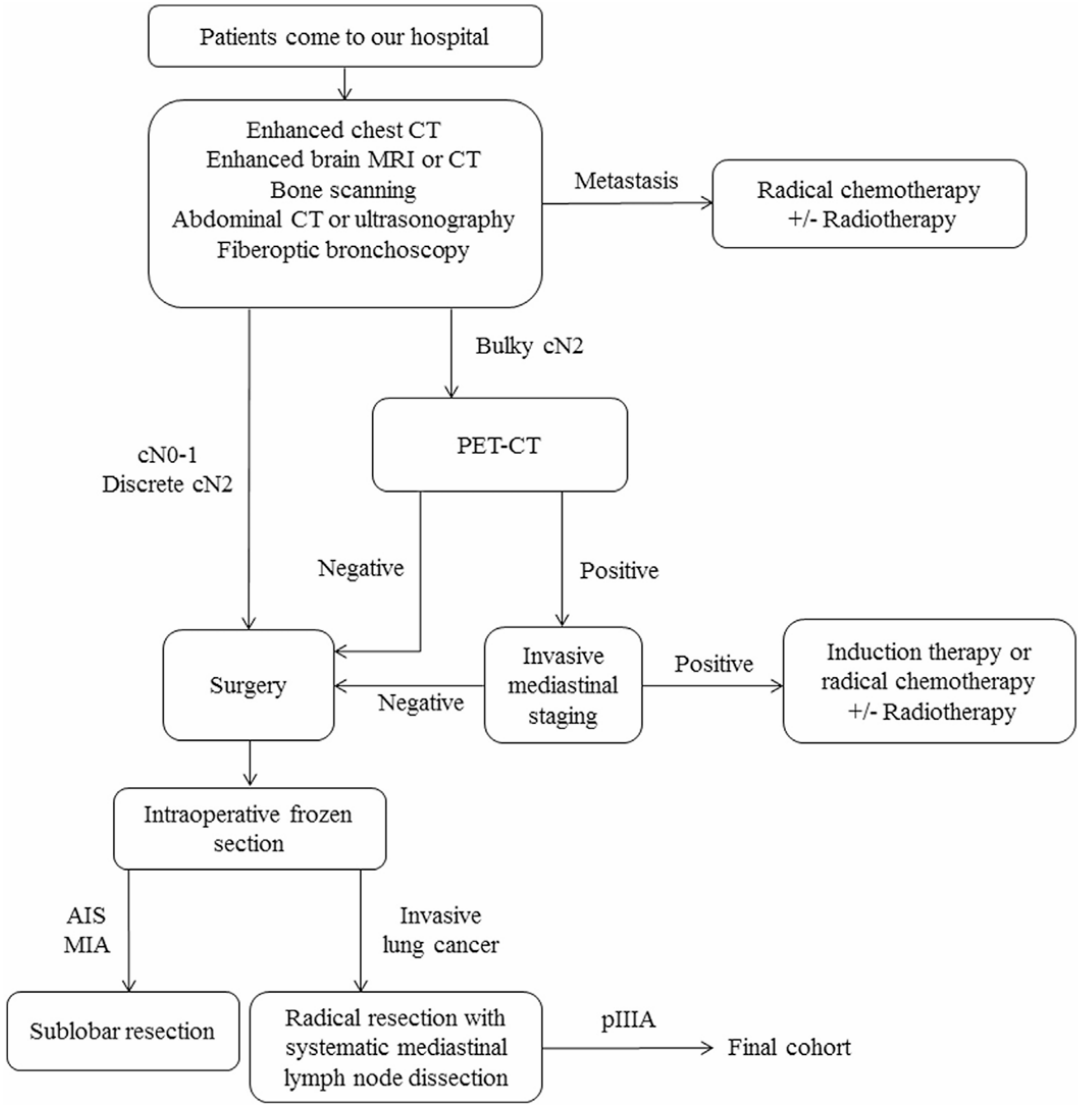
Jae Kwang Yun [a,†], Jin San Bok [b,†], Geun Dong Lee [a], Hyeong Ryul Kim [a], Yong-Hee Kim [a], Dong Kwan Kim [a], Seung-Il Park [a] and Sehoon Choi [a,*]

- Genel sağkalım %44,7
- Evre 3a → %47
- cN2 ve pN2 → %40 sağ kalım daha düşük
- cN1 ve cN2 hastaların sağ kalımı benzer
- mN2 → KTRT daha iyi sonuç
- Adj Kt alanlar RT veya ted almayanlardan daha iyi

Sonuç: Seçilmiş rezektable N2 hastalarda upfront cerrahi uygulanabilir bir seçenek

Upfront surgery as first-line therapy in selected patients with stage IIIA non–small cell lung cancer

Difan Zheng, MD, Ting Ye, MD, Hong Hu, MD, Yawei Zhang, MD, Yihua Sun, MD, Jiaqing Xiang, MD, and Haiquan Chen, MD



- 668 pIIIA (T1-3N2,T3-4N1,T4N0) KHDAK
- %92 R0 rezeksiyon
- Preoperatif
  - 302 hastada klinik N2 (%45,2)
  - 366 hastada klinik N0 (%54,8)
- Postoperatif
  - %84 adjuvan kemoterapi
  - %23 adjuvan radyoterapi
- 6 hasta (%0,9) cerrahiden sonraki 1 ay içinde ex
  - 3'ü cerrahi
  - 3'ü progresyon

n=628 (%94,0)
pN2

Upfront surgery as first-line therapy in selected patients with stage IIIA non–small cell lung cancer

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- 5 yıllık sağ kalım %43
- 5 yıl için de %70 nüks
- Progresyonu etkileyen faktörler
  - Tümör boyutu
  - cN2 durumu
  - pN2b (Multiistasyon)
  - Adjuvan KT olmaması

daha yüksek progresyon riski ile ilişkiliydi.

- Kötü prognostik faktörler
  - ileri yaş
  - Sigara
  - pN2b (Multiistasyon)
  - Cerrahi sınır pozitifliği
  - adjuvan kemoterapi olmaması

Upfront surgery as first-line therapy in selected patients with stage IIIA non–small cell lung cancer

Difan Zheng, MD, Ting Ye, MD, Hong Hu, MD, Yawei Zhang, MD, Yihua Sun, MD, Jiaqing Xiang, MD, and Haiquan Chen, MD

- Sonuç: Upfront cerrahi
  - adenokarsinom
  - cN0
  - pN2a (tek istasyon) uygundur
- Evre IIIA hastalık heterojendir ve tedavi bireyselleştirilmelidir

Letter to the Editor

Upfront surgery is essential in selected patients with stage IIIA non-small cell lung cancer

Difan Zheng[1,2], Haiquan Chen[1,2]

- Tm Çapı
- Multiistasyon N1
- Multiistasyon N2 bağımsız risk faktörleri
- 7 numara (+) kötü prognoz

- Neoadjuvan vs adjuvan KT: benzer sonuçlar

Lokal ileri evre akciğer kanseri Upfront cerrahi - Tedavi seçimi

Uygun

- Lobektomi ile operable
- Tek istasyon N2
  - EBUS ile doğrulanmış minimal N2
  - Subkarinal negatif
- Non-bulky N2 (<3 cm)
  - Ekstranodal yayılım yok
- PET SUV düşük
- ECOG 0–1
- R0 olasılığı yüksek

Uygun değil

Bulky N2

Multistation N2

Yüksek tümör yükü

Şüpheli R0

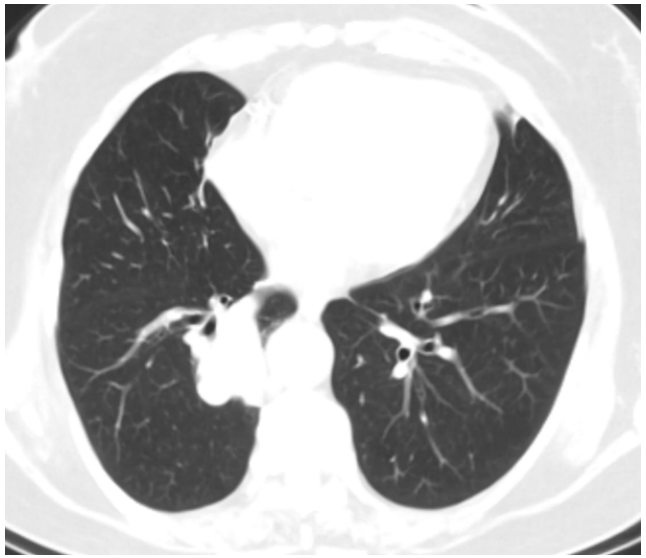
Ramnath. Chest 2013;143:e314S–e340S
Bertolaccini L, Front Oncol 2022;12:933278
Maniwa T, Surg Today 2016;46:699–704
Hishida T, Jpn J Clin Oncol 2014;44:85–92
Deng H, BJS Open,8,2, 2024, zrae008

Lokal ileri evre akciğer kanseri Upfront cerrahi - Tedavi seçimi

- Neoadjuvan tedaviye uygun olmayan hastalar
- Rezektable T4
  - Sol atriyum
  - Vertebra
- Mediasten invazyonu olmayan büyük tümörler

Olgu 1

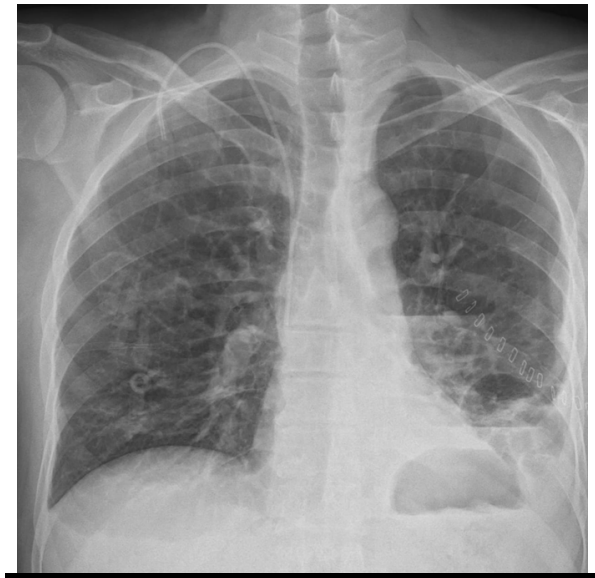
- 78 y Kadın
- Böbrek yetmezliği, üriner stent
- Bypass koroner stent



VATS Sağ alt lobektomi
Postoperatif 3 gün taburcu
Adenokarsinom 5 cm 11 ve 7 numara pozitif

Olgu 2

49 y E
Madde bağımlılığı ve sigara
Kaşektik
Ateş yüksekliği öksürük balgam



Upfront Cerrahi- Riskler ve Eleştiriler

- Güncel başarılı immünoterapi sonuçları
- Sürpriz multistasyon N2 riski
- Cerrahi sonrası adjuvan tedaviye başlanılamaması veya tolere edilememesi
- Sistemik hastalığın erken kontrol edilememesi

Uludağ Üniversitesi Deneyimi

- Ocak 1996-aralık 2024
- Anatomik cerrahi rezeksiyon→ 2050 hasta

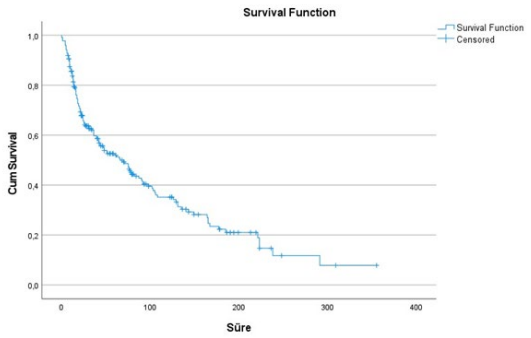
	n	Lob	VATS	2024 (n)	2024 (VATS)	Dönüşüm	Morbidite	Mortalite	pTY
Upfront	1221 (%59)	%80	%38	%63	%88	%5	%34	%2	
NT	829 (%40)	%80	%15	%37	%40	%15	%44	%3	%15
KT	611 (%74)			%75					%10
KTRT	164 (%20)			%4					%32
KT-İ	54 (%0,02)	%90	%53	%21	%73	%6	%39	%0	%41

Uludağ Üniversitesi Deneyimi

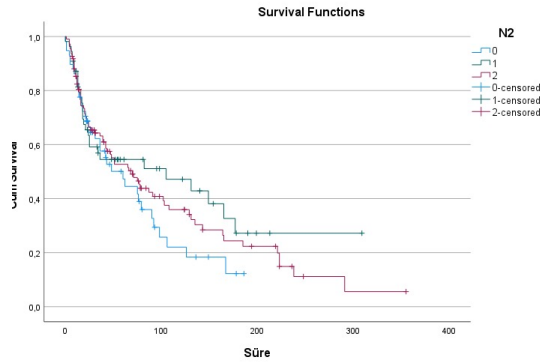
- Ocak 1996-aralık 2024
- Anatomik cerrahi rezeksiyon→ 2050 hasta
- Upfront (n=1221) → Evre 3 (n=233,%19) (47, %20 kadın, 186 Erkek, ort yaş 62)
- Hastaların %40'ı pet öncesi dönemden (p<0,05)
  - 13 segmentektomi (%6) → 11 (%85) sol taraf
  - 185 lobektomi (%79)
  - 35 Pnömonektomi (%15)→ 15 hasta N2 → 1 hasta N2b (salvage)
- VATS %30 (Son 6 yıl→ %48)
- Morbidite %33
- Mortalite%2

Uludağ Üniversitesi Deneyimi-Upfront cerrahi

- Evre 3
  - 5 yıllık sağ kalım %52,6



- Evre 3 - N durumuna göre
  - N0 →5 yıllık sağ kalım %50
  - N1 →5 yıllık sağ kalım %54
  - N2→ 5 yıllık sağ kalım %52 (p=0,45)



pTY (tam yanıt)

5 yıl sağ kalım %69

Rekürrens %25

KT →%21

KTRT→ %32

KT-İ → %19 (p=0,3)

Table 1. Characteristics of patients with pCR	
Clinical stage n (%)	132 (16.22%)
2	21 (15.9%)
3	102 (77.3%)
4	9 (6.8%)
Neoadjuvant treatment n (%)	
Chemotherapy	63/612 (10.3%)
Chemoradiation	53/162 (32.7%)
Chemotherapy and imm.	16/39 (41%)
PET /CT Suvmax median (range)	
pretreatment	13.7 (0-22)
posttreatment	4 (0-7)
Lung resection	
Segmentectomy	6 (4.5%)
Lobectomy	110 (83.3%)
Pneumonectomy	16 (12,2%)
Morbidity	48 (36.36%)
Mortality (90 day)	2 (1.5%)
5 year suvival	68.7%
Recurrens	33 (25%)
Distant	21 (63.6%)
Local	6 (18.2%)
Distant and Local	6 (18.2%)
Recurrence time (months) n (%)	
Within 24	66%
(More) 24	34%
In the analyzes made; There was no significant relationship between age, gender, histopathological type, reason and type of induction treatment, surgical method applied, presence of adjuvant treatment, and recurrence and survival.	

Akılda kalanlar

- Evre II–IIIA (seçilmiş IIIB) heterojen bir grup
  - Benzer sağkalım → farklı cerrahi riskler
- Tek tedavi algoritması yok
  - Karar = hasta bazlı + multidisipliner
- Evre III cerrahisi
  - Yüksek hacimli merkezlerde
  - Pnömonektomi mümkün olduğunca az yapılmalı
- Lokal ileri evre akciğer kanserinde cerrahi başarı
  - doğru hastada
  - doğru zamanda
  - doğru sıralamaya bağlıdır

Akılda Kalanlar

- Beklenilmeyen N2 → cerrahiyi durdurmak için tek başına yeterli değil
- Single station / non-bulky N2 = cerrahi adayı olabilir
  - R0 mümkünse cerrahi geciktirilmemesi için
  - Neoadjuvan tedaviden fayda göremeyecek hastalar için uygun olabilir

ilginiz için tesekkürler...