



# EP07.10: Extensive Lymphadenectomy, Not Resection Extent, Improves Survival in ≤2 cm Node-Positive NSCLC

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## INTRODUCTION

For patients with small-sized (≤2 cm) non-small cell lung cancer (NSCLC) undergoing sublobar resection, completion lobectomy is recommended if nodal metastasis is detected intraoperatively, whereas adjuvant systemic therapy is preferred when nodal upstaging is confirmed postoperatively. The actual benefit of extended pulmonary resection in this specific population of patients with node-positive disease remains unclear. We aimed to evaluate whether parenchymal-sparing resection combined with thorough lymphadenectomy offers a viable alternative to standard lobectomy.

## METHODS

We analyzed records of patients with surgically resected, small-sized, node-positive NSCLC from the SEER database (2010-2022). The primary endpoint was lung cancer-specific survival (LCSS), and the secondary endpoint was overall survival (OS). Multivariate Cox and Fine-Gray competing risk models identified prognostic factors for OS and LCSS. Propensity score matching was utilized to compare outcomes between resection types.

## DISCUSSION AND CONCLUSION

### Actionable Take Away Message

- The survival benefit in stage IIA patients is directly attributable to cancer control rather than competing non-cancer specific causes.
- The potential harm observed in stage IB patients strongly argues against routine use of adjuvant chemotherapy in this group.

### Future Direction for Research

- Performance status, detailed information about systemic therapy and molecular testing results should be included in future analysis.

## REFERENCES & ACKNOWLEDGEMENTS

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## RESULTS

- Of 2,670 patients, 84% underwent lobectomy and 16% sublobar resection. Lobectomy was associated with more thorough lymphadenectomy (lower positive lymph node ratio [pLNR]) compared to segmentectomy and wedge resection, with pLNR values of 17% vs. 25% vs. 33%, respectively.
- Multivariate analysis showed resection extent was not significantly associated with OS or LCSS. However, high pLNR was an independent adverse factor for OS (HR 1.625, 95% CI 1.436-1.838, P<0.001) and LCSS (SHR 1.672, 95% CI 1.448-1.930, P<0.001).
- In the matched cohort, no significant survival differences were observed between lobectomy and sublobar resection (OS: P=0.075; LCSS: P=0.666), while high pLNR remained significantly associated with inferior outcomes (both P<0.001).

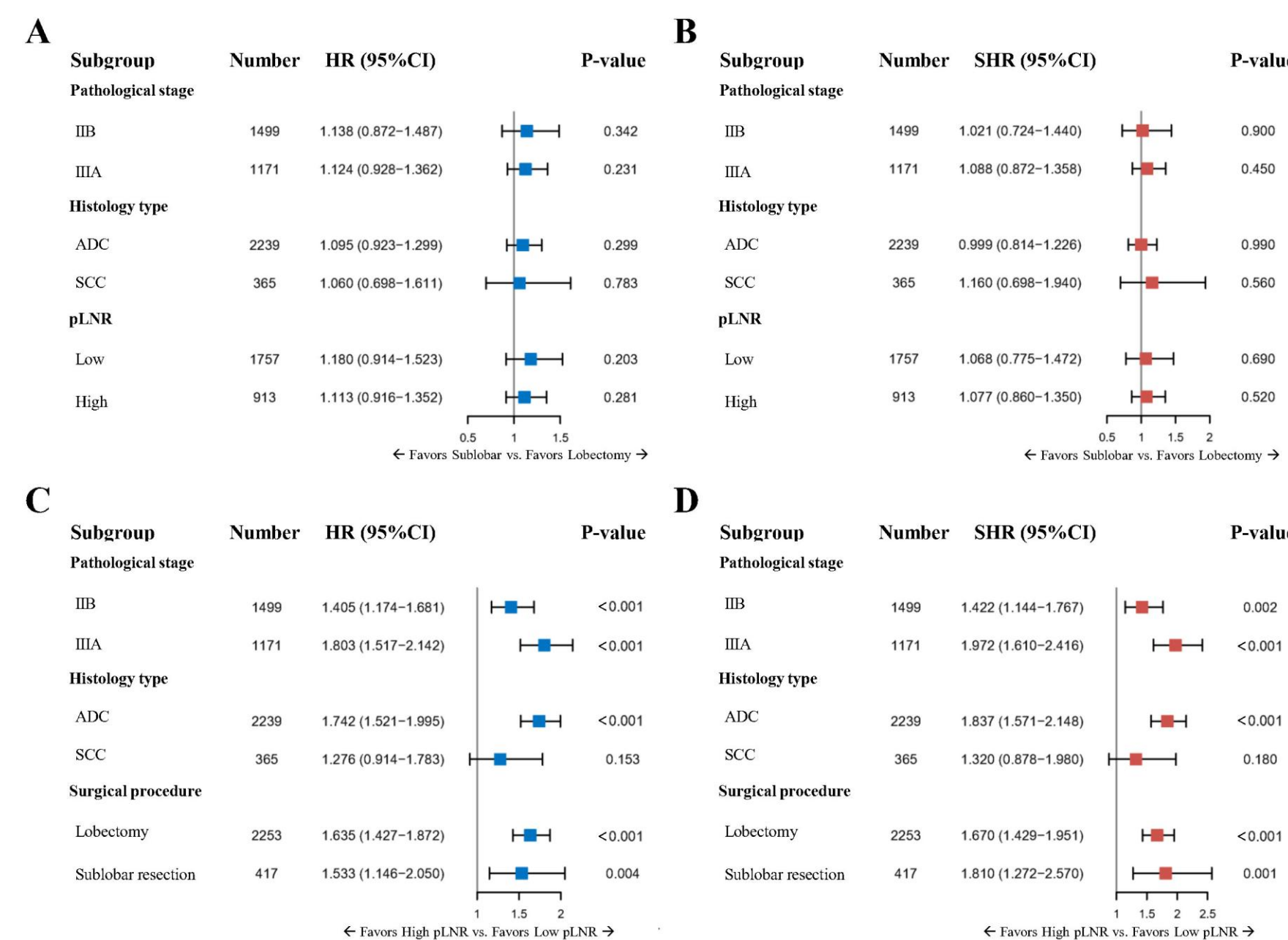


Figure 1. Adjusted multivariate regressions comparing lobectomy vs. sublobar resection (A-B) and low vs. high pLNR (C-D) for OS and LCSS in surgically resected small-sized node-positive NSCLC subgroups stratified by pathological stage, histologic type, surgical procedure and pLNR status. pLNR, positive lymph node ratio; OS, overall survival; LCSS, lung cancer-specific survival

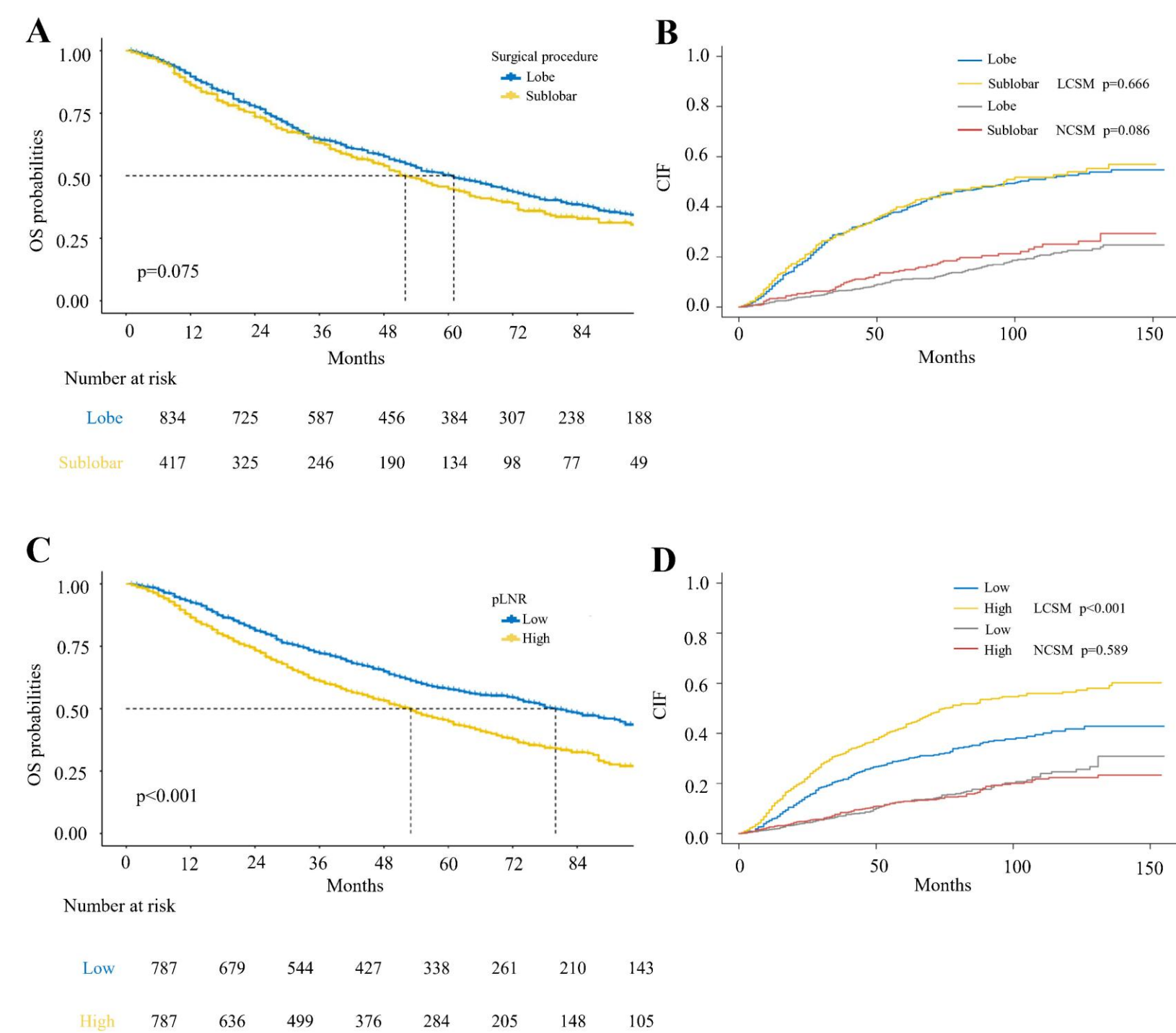


Figure 2. Kaplan-Meier survival curves of OS and CIF of LCSM/NCSM stratified by surgical procedure (A-B) and pLNR (C-D) in propensity score matched cohorts. OS, overall survival; CIF, cumulative incidence function; LCSM, lung cancer-specific mortality; NCSM, non-cancer-specific mortality; pLNR, positive lymph node ratio.