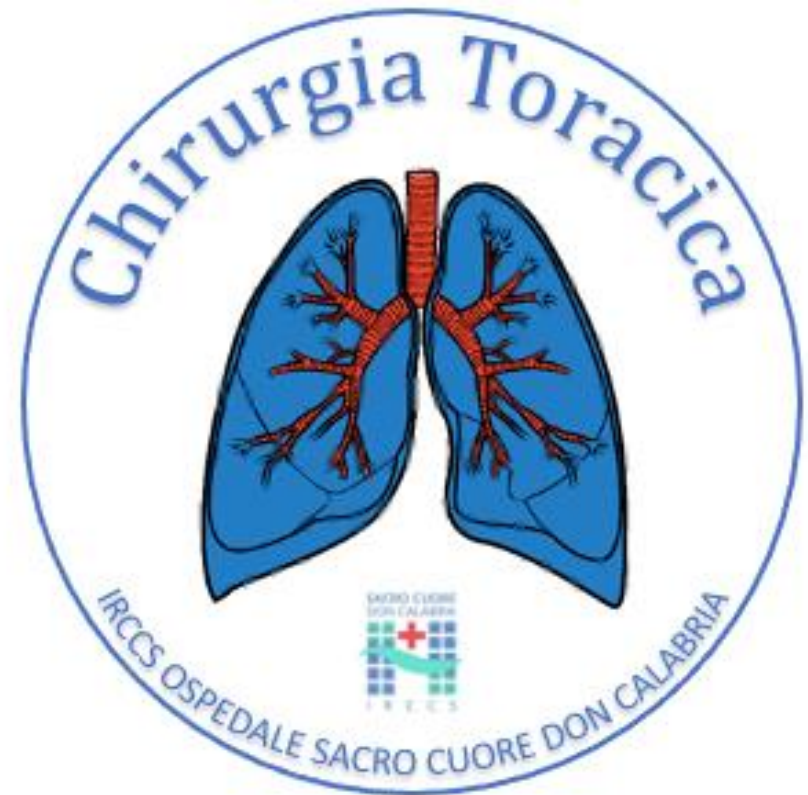
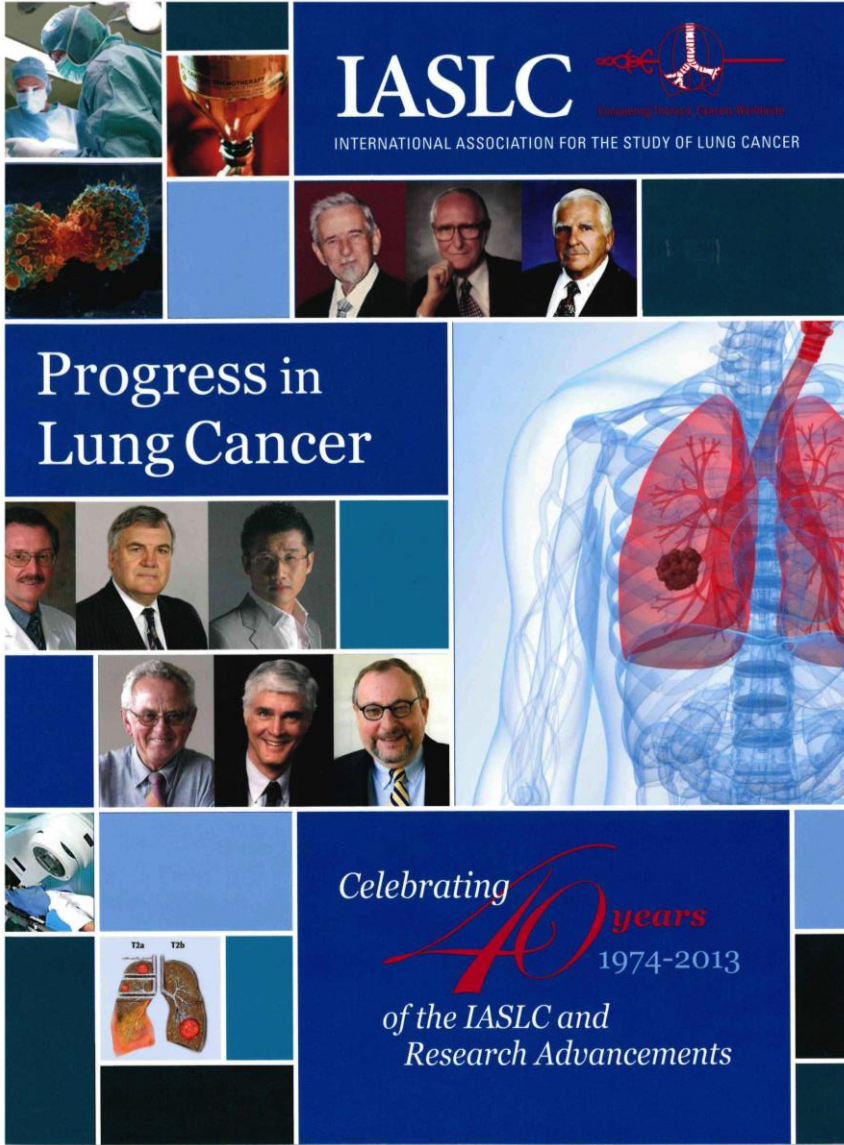


# Trattamento del NSCLC stadio I-II-III.

Ruolo della  
Chirurgia





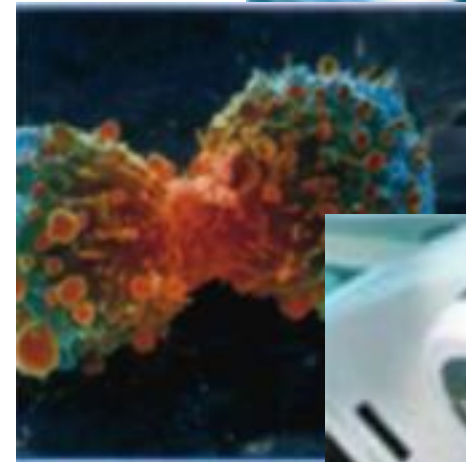
**IASLC**  
Improving Lung Cancer Worldwide  
 INTERNATIONAL ASSOCIATION FOR THE STUDY OF LUNG CANCER

**Progress in Lung Cancer**

*Celebrating 40 years*  
 1974-2013  
 of the IASLC and  
 Research Advancements

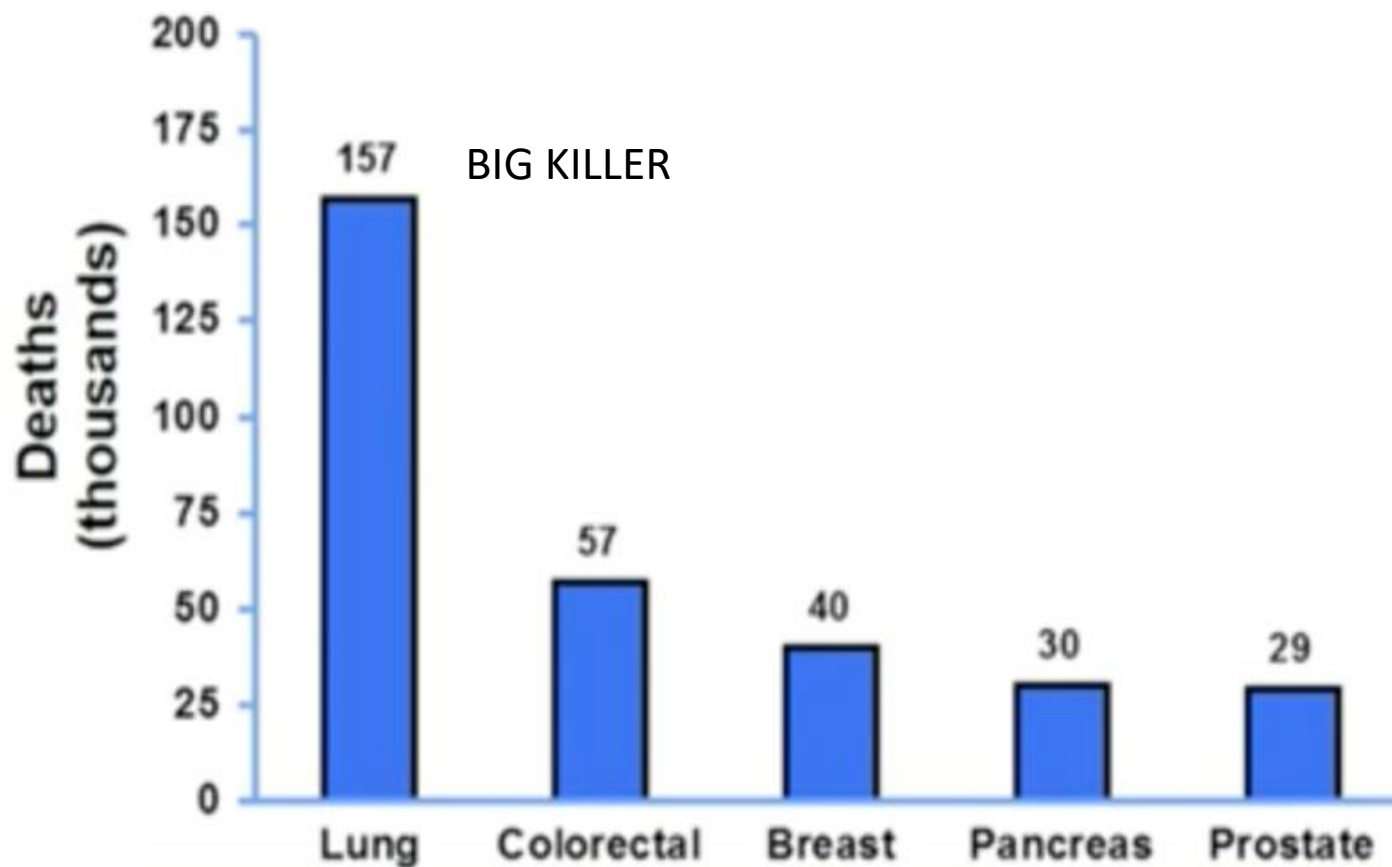
T2a T2b

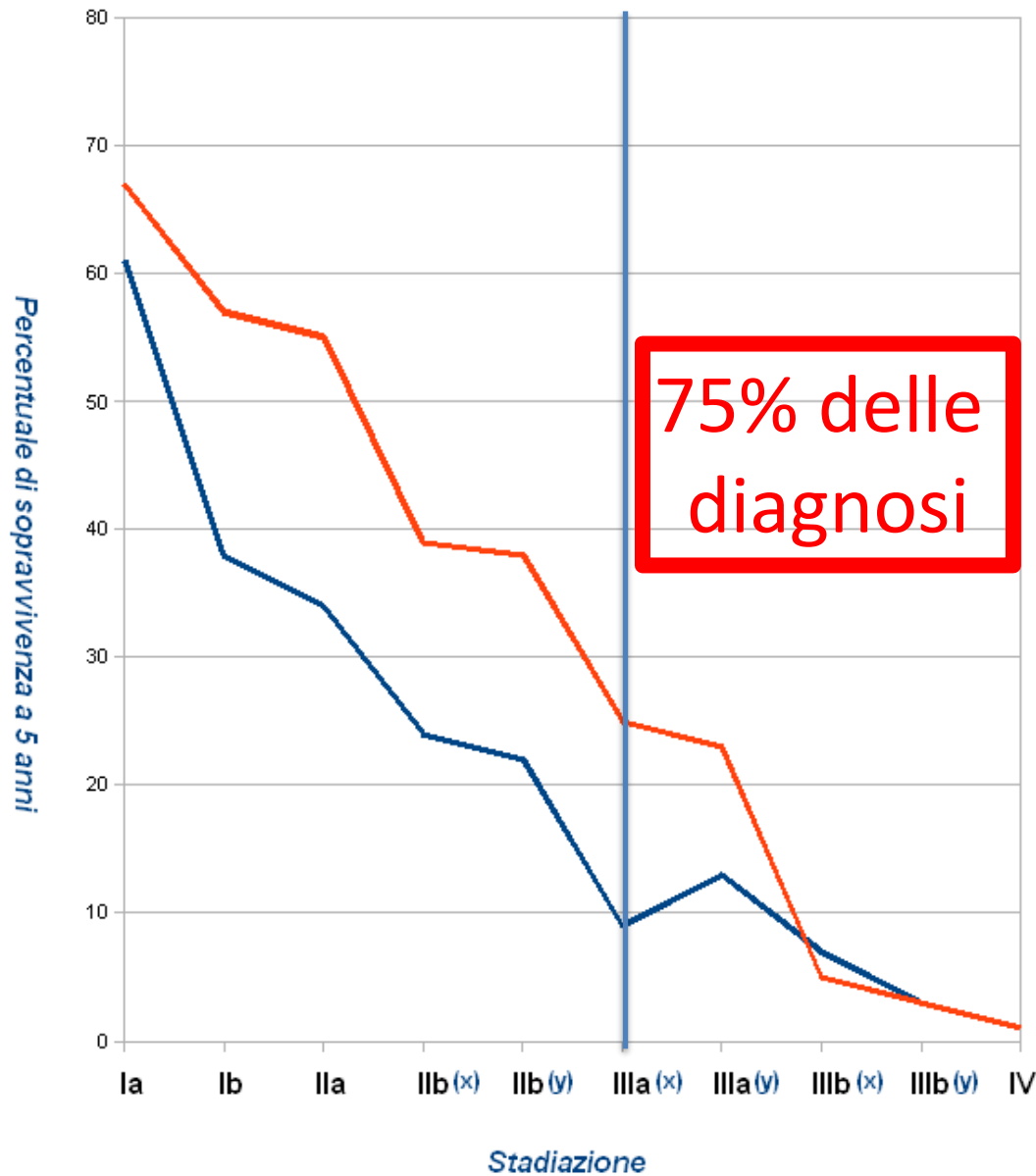
This collage features a central graphic of a human torso with red lungs and a dark tumor. Surrounding it are various images: surgeons in an operating room, a golden trophy, a microscopic view of cancer cells, portraits of several men in suits, and a diagram of lung cancer stages labeled T2a and T2b.



## Annual Cancer Death Rate (US)

---





— = *TNM patologico (pTNM)*  
 — = *TNM clinico (cTNM)*

**Ia** T1 N0 M0

**Ib** T2 N0 M0

**IIa** T1 N1 M0

**IIb(x)** T2 N1 M0

**IIb(y)** T3 N0 M0

**IIIa(x)** T3 N1 M0

**IIIa(y)** T1-2-3 N2 M0

**IIIb(x)** T4 N0-1-2 M0

**IIIb(y)** T1-2-3-4 N3 M0

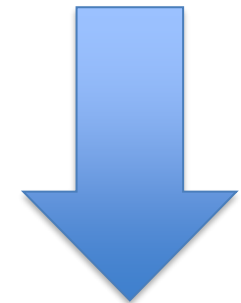
**IV** Ogni T ogni N M1

T/M	Label	N0	N1	N2	N3
T1	T1a $\leq 1$	IA1	IIB	IIIA	IIIB
	T1b $1-2$	IA2	IIB	IIIA	IIIB
	T1c $> 3$	IA3	IIB	IIIA	IIIB
T2	T2a <i>Cent. Yrs P</i>	IB	IIB	IIIA	IIIB
	T2a <i>Peri. Yrs P</i>	IB	IIB	IIIA	IIIB
	T2b	IIA	IIB	IIIA	IIIB
T3	T3 $\leq 7$	IIB	IIIA	IIIB	IIIC
	T3 <i>Inv</i>	IIB	IIIA	IIIB	IIIC
	T3 <i>Satell</i>	IIB	IIIA	IIIB	IIIC
T4	T4 $> 7$	IIIA	IIIA	IIIB	IIIC
	T4 <i>Inv</i>	IIIA	IIIA	IIIB	IIIC
	T4 <i>Ipsi Nod</i>	IIIA	IIIA	IIIB	IIIC
M1	M1a <i>Contr Nod</i>	IVA	IVA	IVA	IVA
	M1a <i>PI Dissem</i>	IVA	IVA	IVA	IVA
	M1b <i>Single</i>	IVA	IVA	IVA	IVA
	M1c <i>Multi</i>	IVB	IVB	IVB	IVB

STADI "PRECOCI"

STADI AVANZATI

2/3 DEI TUMORI DIAGNOSTICATI



5-Year Survival (%)



Type	IA1	IA2	IA3	IB	IIA	IIB	IIIA	IIIB	IIIC	IVA	IVB
Clinical	92	83	77	68	60	53	36	26	13	10	0
Pathologic	90	85	80	73	65	56	41	24	12	-	-

# Lung Cancer Stage Classification (8<sup>th</sup> Edition)

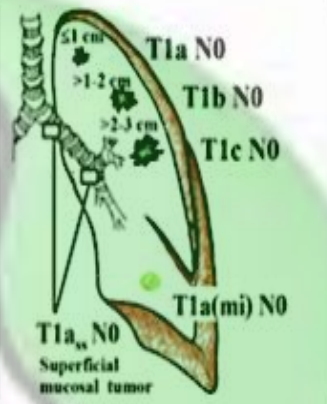


**General Note:**  
 All Stage I-III tumors are M0  
 Tx, Nx should be used only if no information at all is available about T or N stage (including no clinical staging information).  
 Mx is not allowed, because symptoms and physical exam information is always available.

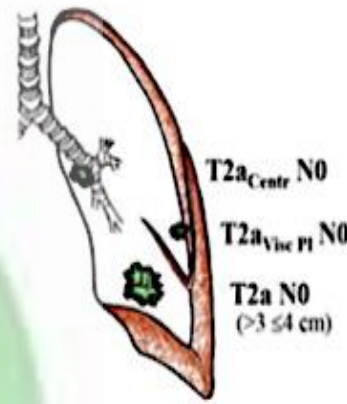
## Stage 0



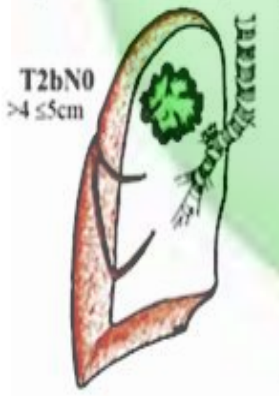
## Stage IA



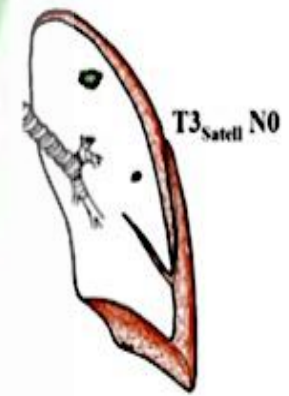
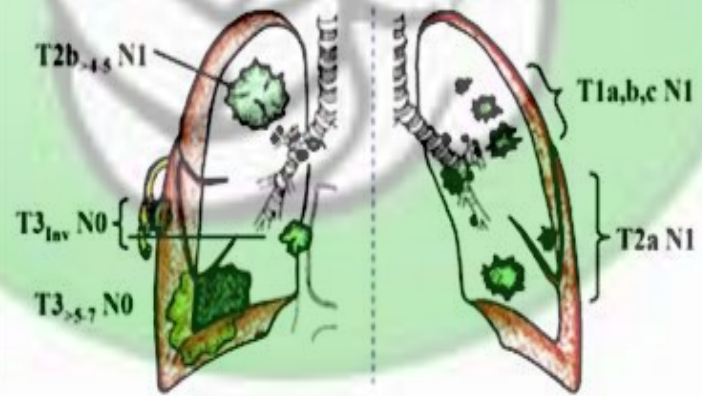
## Stage IB



## Stage IIA



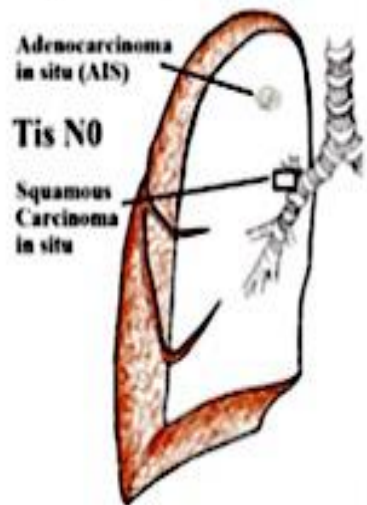
## Stage IIB



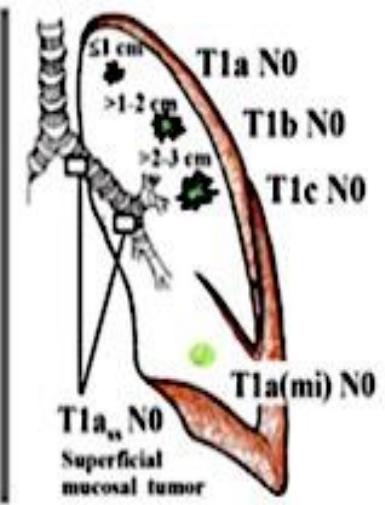
# STADIO I (ALL)

**General Note:**  
 All Stage I-III tumors are M0  
 Tx, Nx should be used only if no information at all is available about T or N stage (including no clinical staging information).  
 Mx is not allowed, because symptoms and physical exam information is always available.

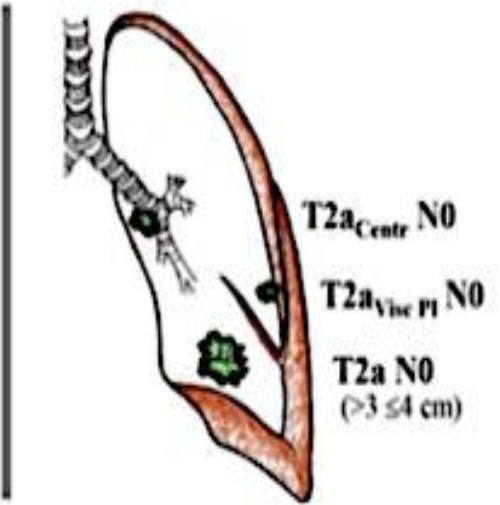
**Stage 0**



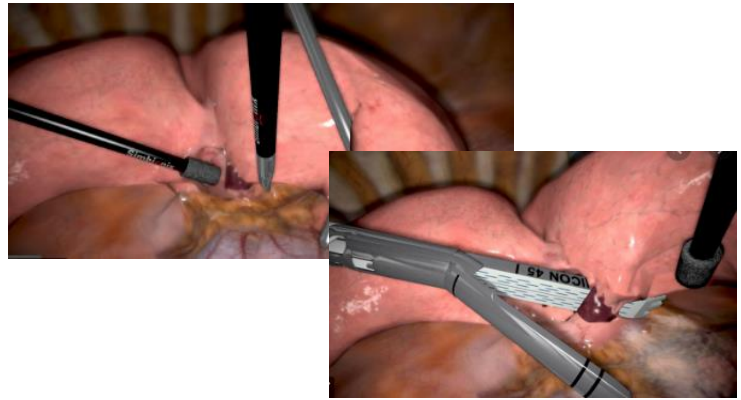
**Stage IA**



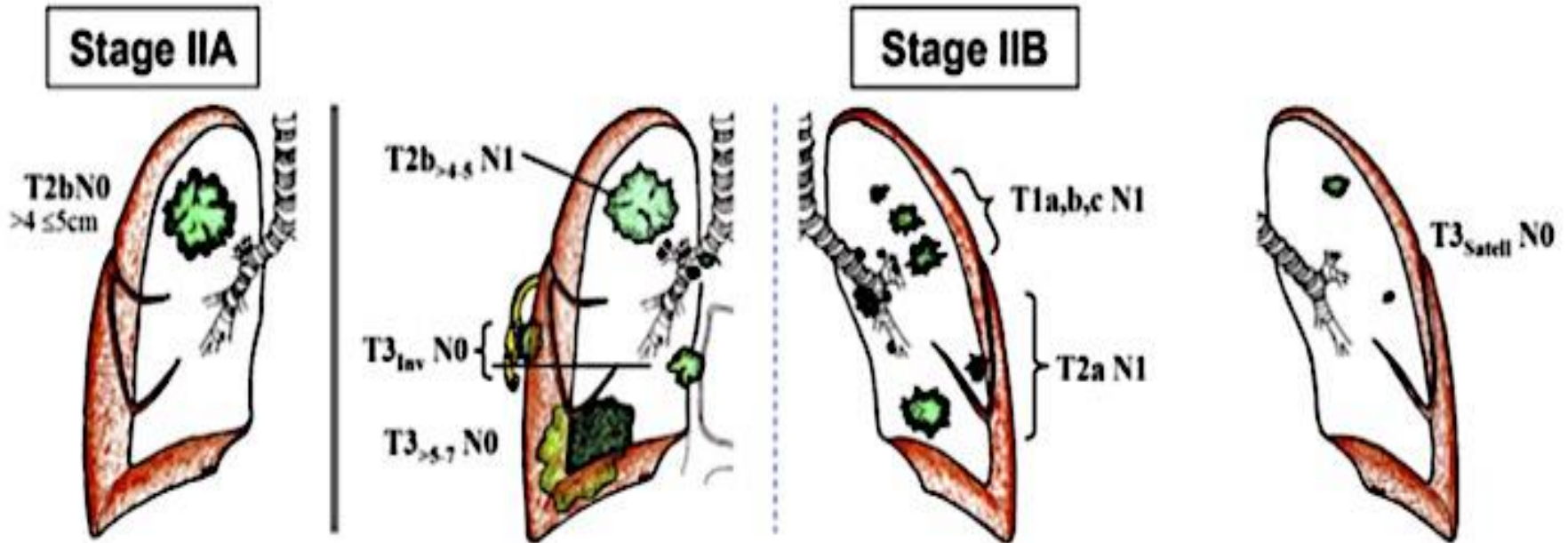
**Stage IB**



**VATS**  
**RATS**

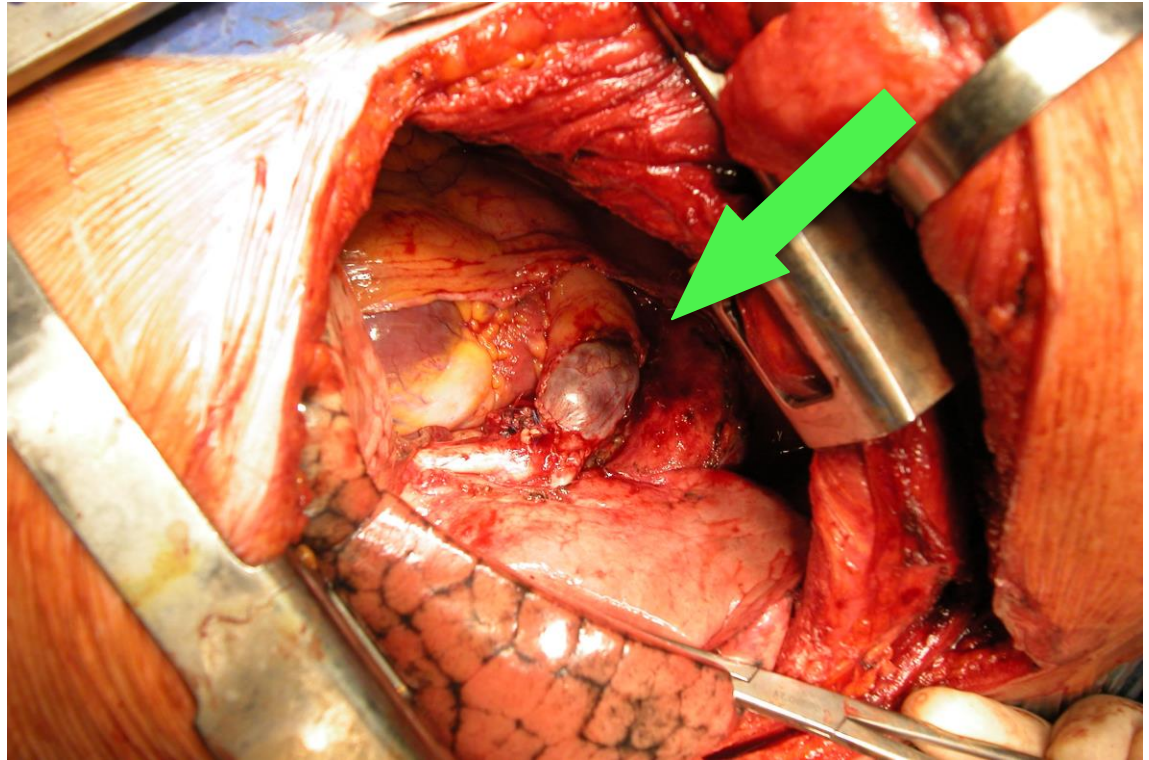
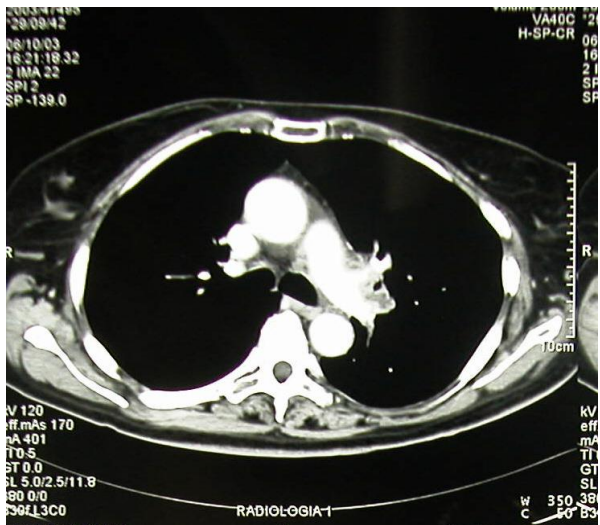
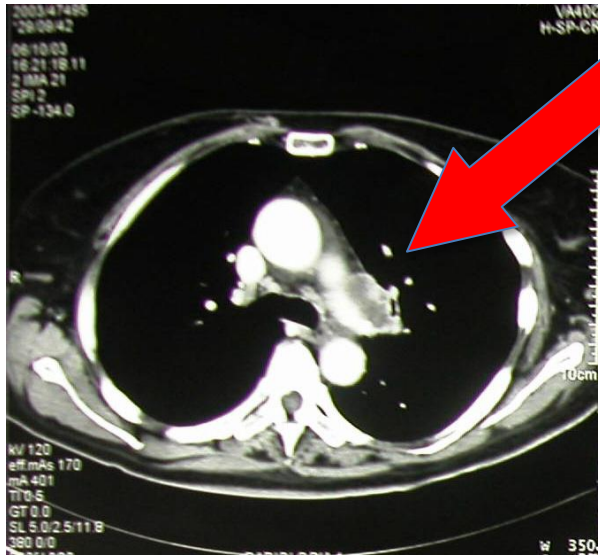


# STADIO II (ALL)

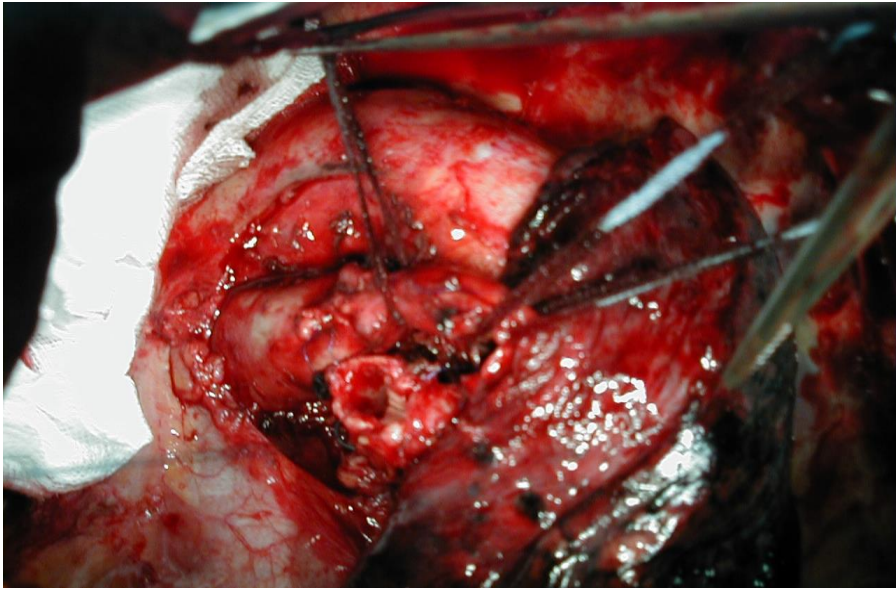
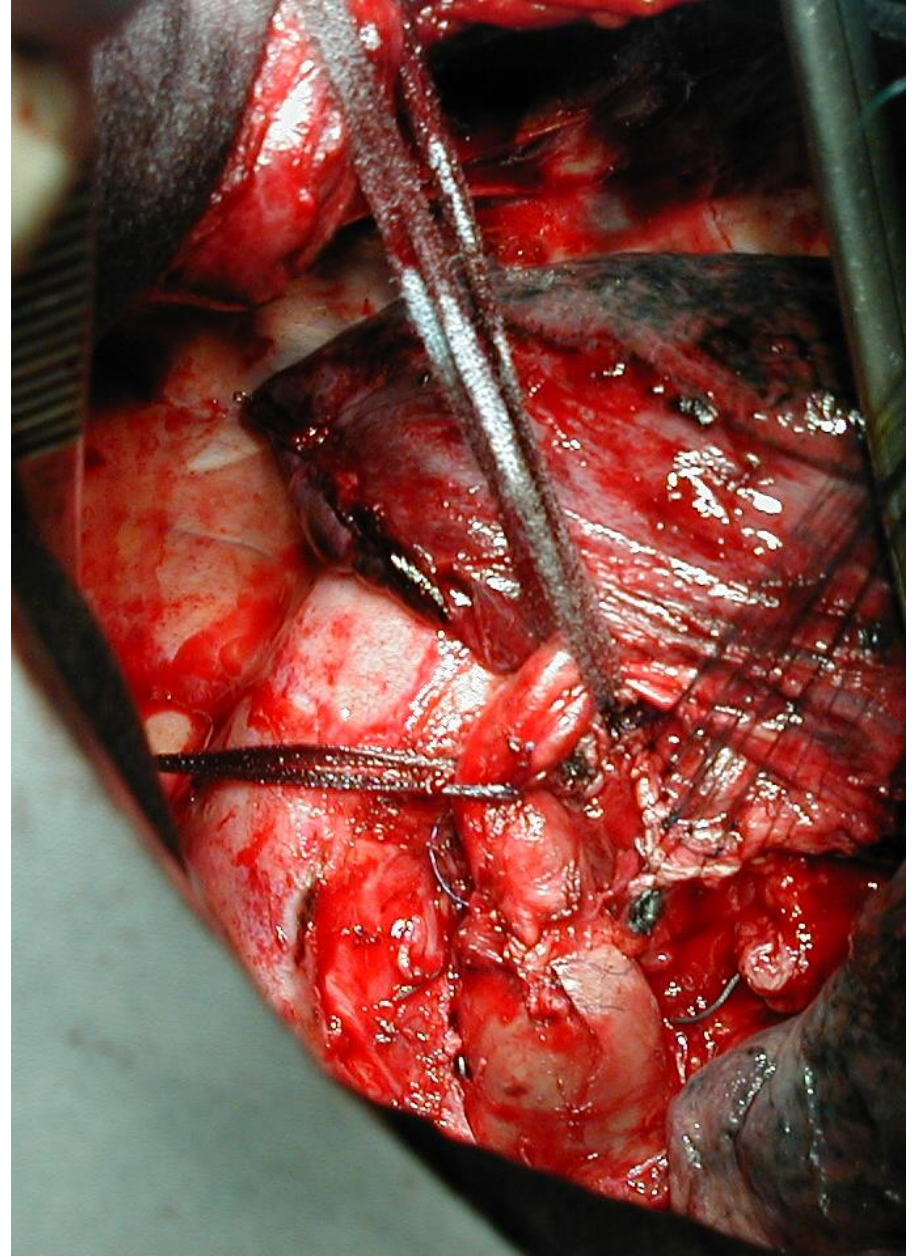
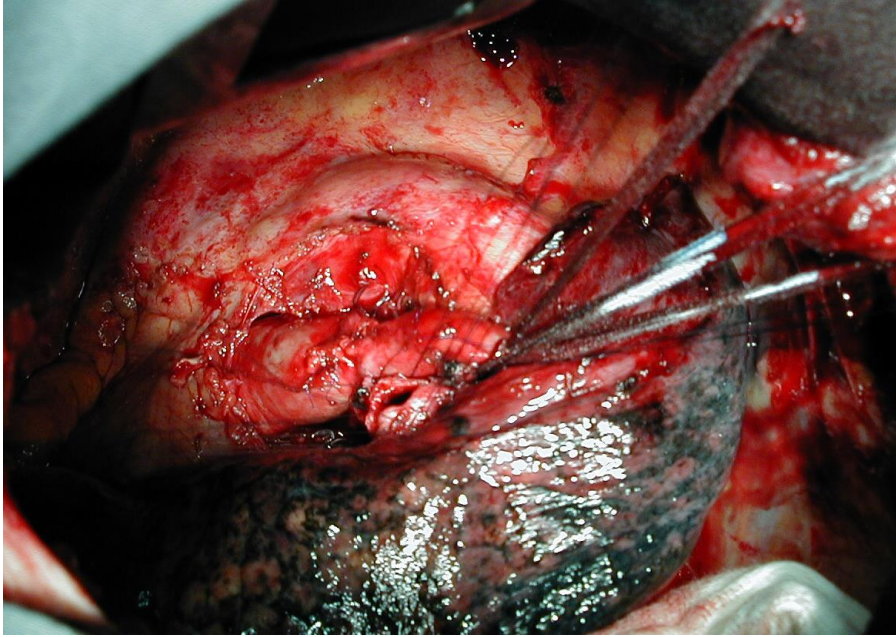


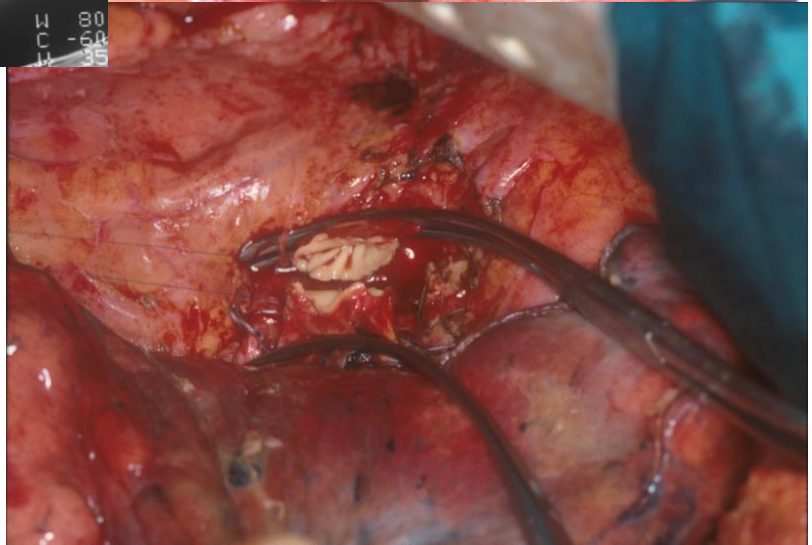
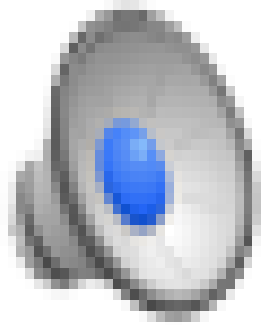
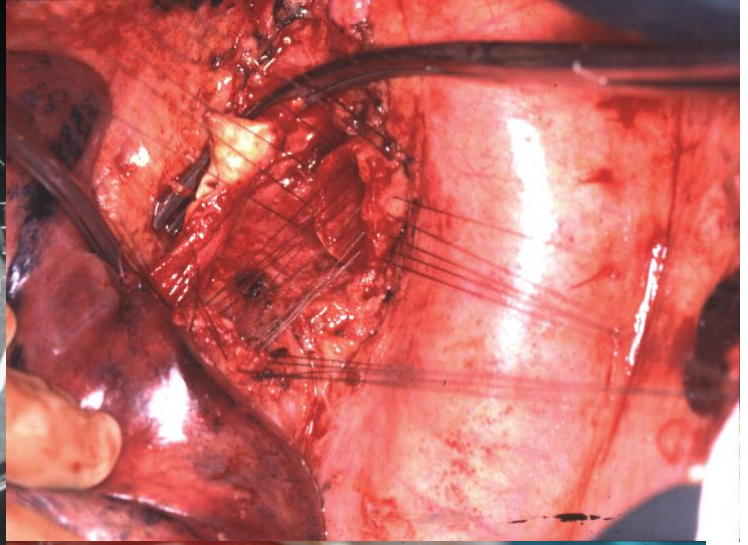
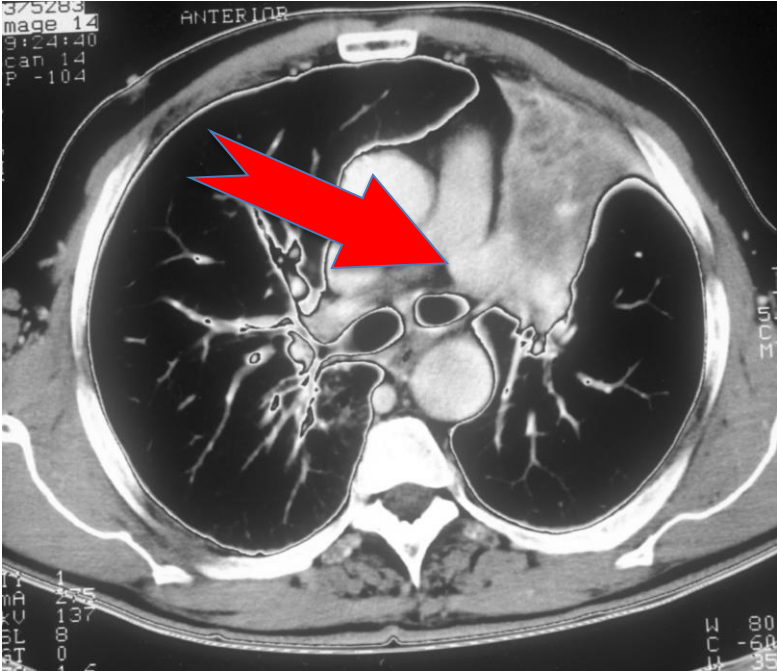
**Chirurgia di risparmio  
polmonare: NO  
PNEUMONECTOMIA.**



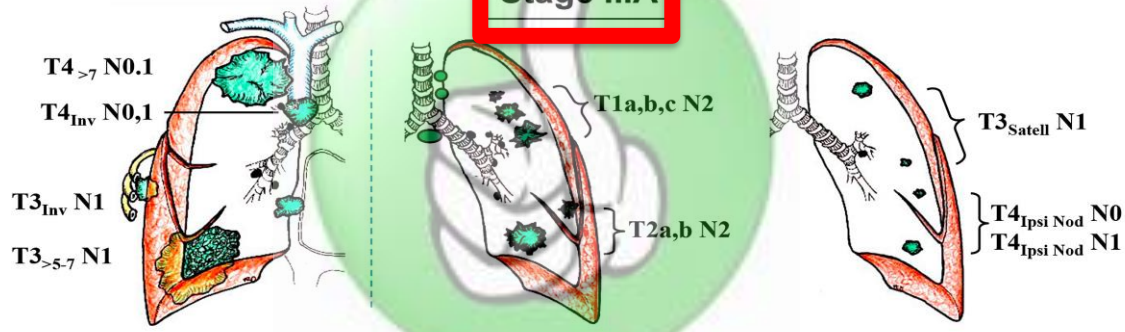


**PLASTICA ARTERIOSA CON  
PATCH DI PERICARDIO**





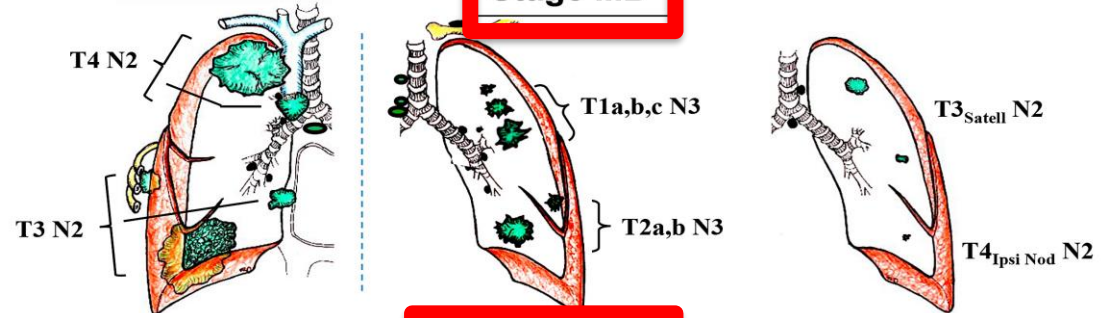
**Stage IIIA**



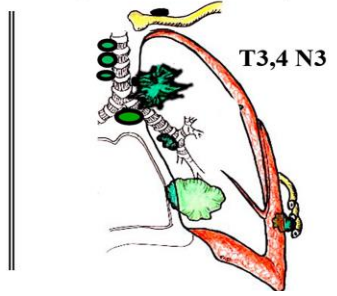
Specific Notes:  
 Tumor size defined as largest dimension of the solid (imaging, c-stage) or invasive (p-stage) component  
 Direct extension of the primary tumor into an adjacent node counts as nodal involvement  
 Extension of a nodal metastasis into a T structure does not count for the T category  
 The highest T category is used when there is a discrepancy between T by size or by other factors



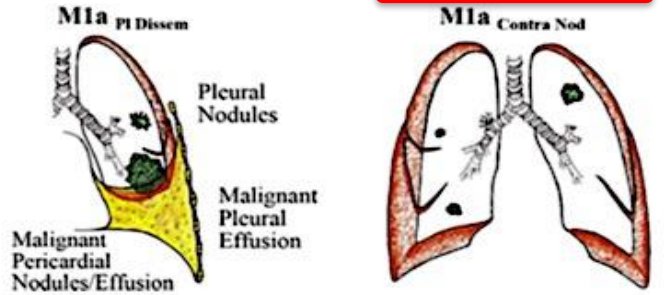
**Stage IIIB**



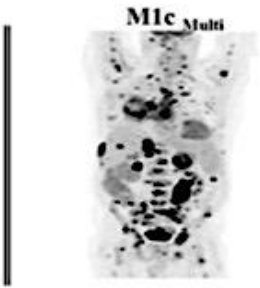
**Stage IIIC**



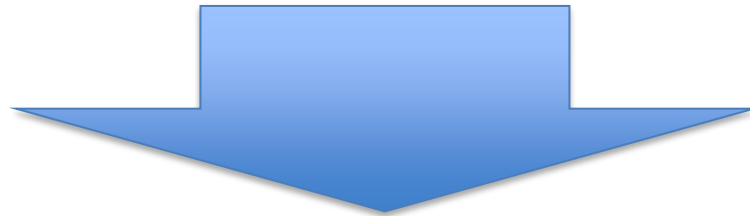
**Stage IVA**



**Stage IVB**



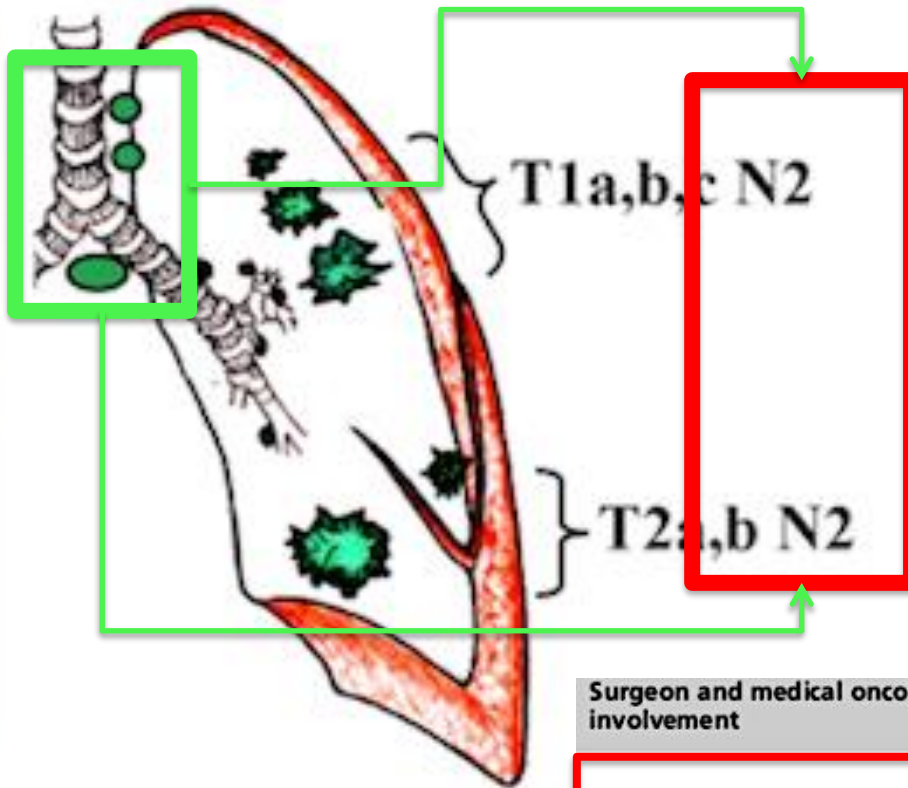
- Chirurgia esclusiva = risultati scadenti
- Radioterapia esclusiva = risultati scadenti
- Chemioterapia esclusiva = risultati scadenti



- APPROCCIO MULTISCIPLINARE

“It may best be described as **chemotherapy-based multimodality therapy**”.

# STADIO III (N2)

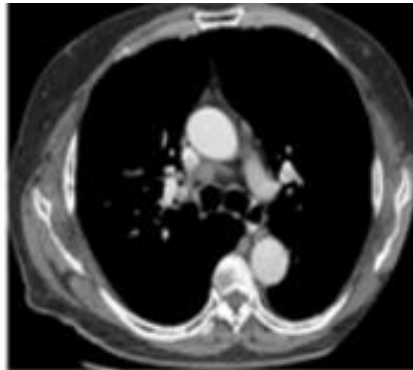


Surgeon and medical oncologist preferences for management of non-small cell lung cancer with N2 involvement

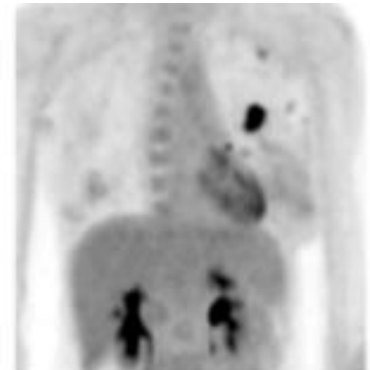
Clinical Scenario	Thoracic Surgeons (n = 513) <sup>9</sup> (%)		Medical Oncologists (n = 406) <sup>10</sup> (%)	
	Role for Surgery	Definitive Chemo/XRT	Role for Surgery	Definitive Chemo/XRT
Single-station, microscopic disease	96	4	92	8
Multistation, macroscopic disease	82	18	48	52
N2 disease and requires R pneumonectomy	30 (pneumonectomy if N2 downstaged) 5 (pneumonectomy regardless of N2 status) 33 (attempt lobectomy if N2 downstaged) 7 (attempt lobectomy only if N2 downstaged)	22	N/R	N/R
Poor PFTs, N2 disease and requires right pneumonectomy	50 (attempt lobectomy)	49	N/R	N/R



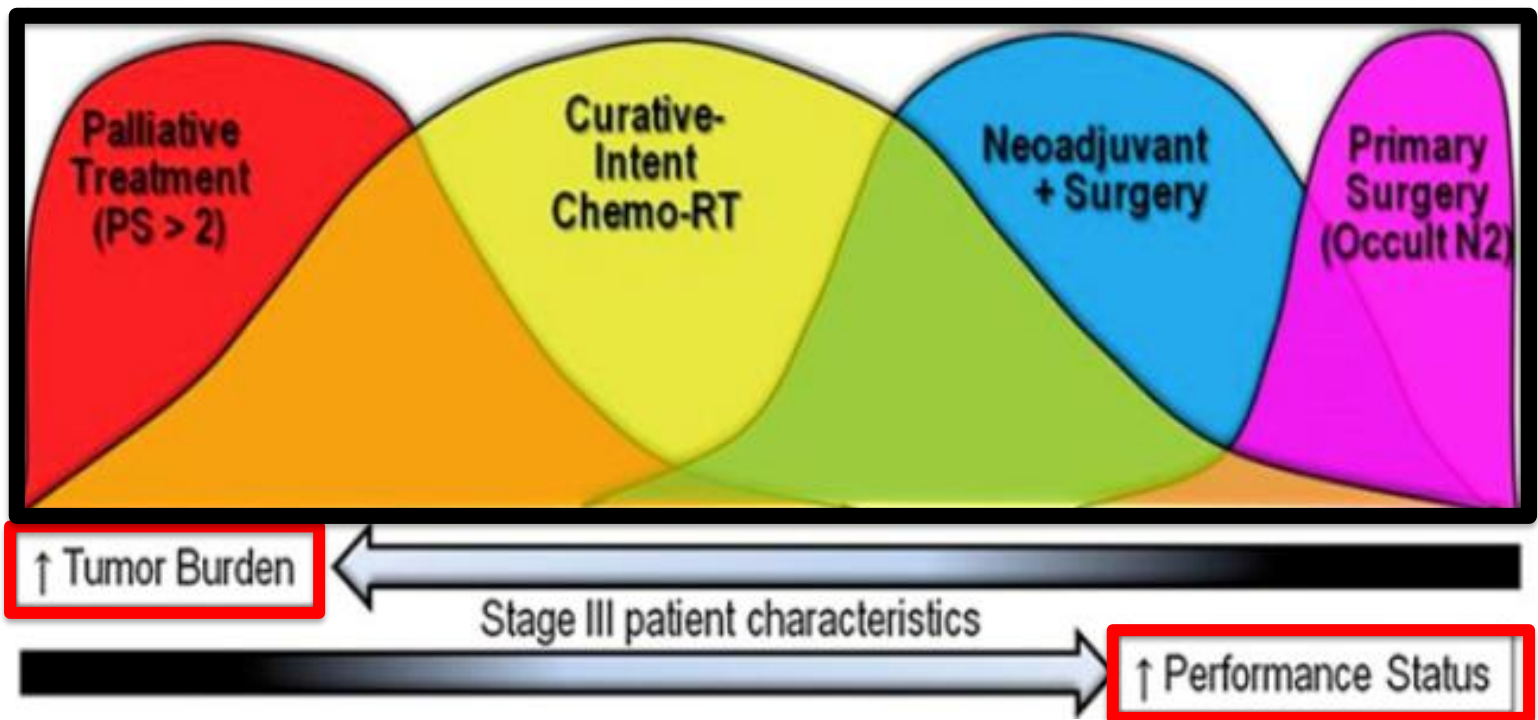
Mediastinal Infiltration



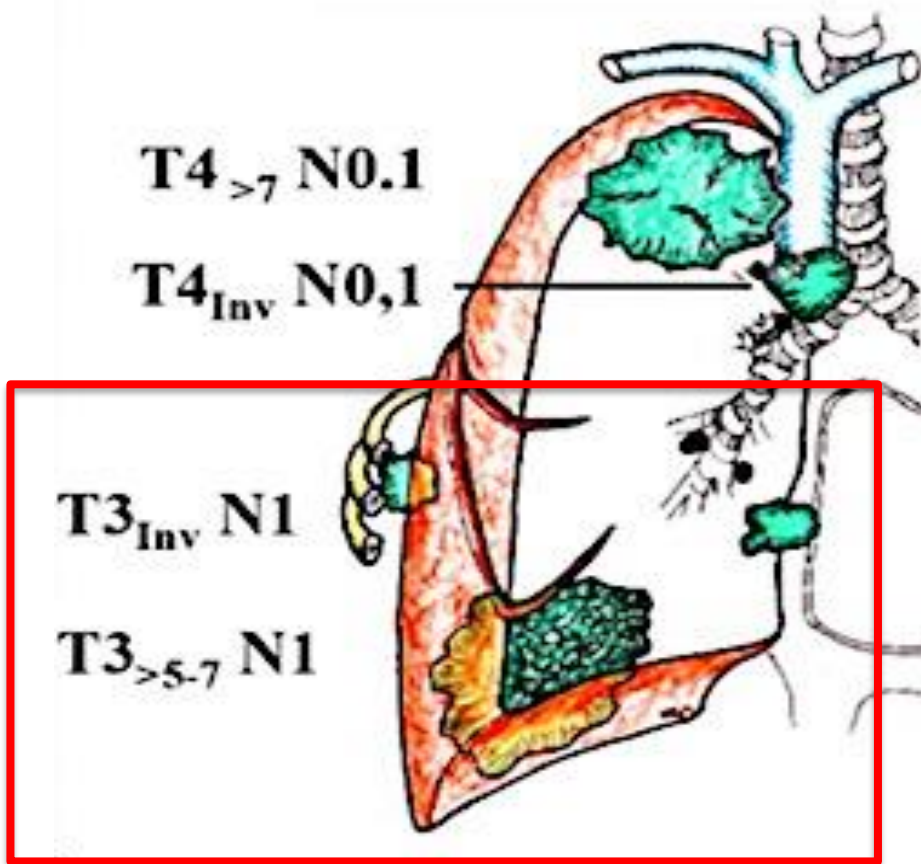
Discrete node enlargement



Clinically occult N2

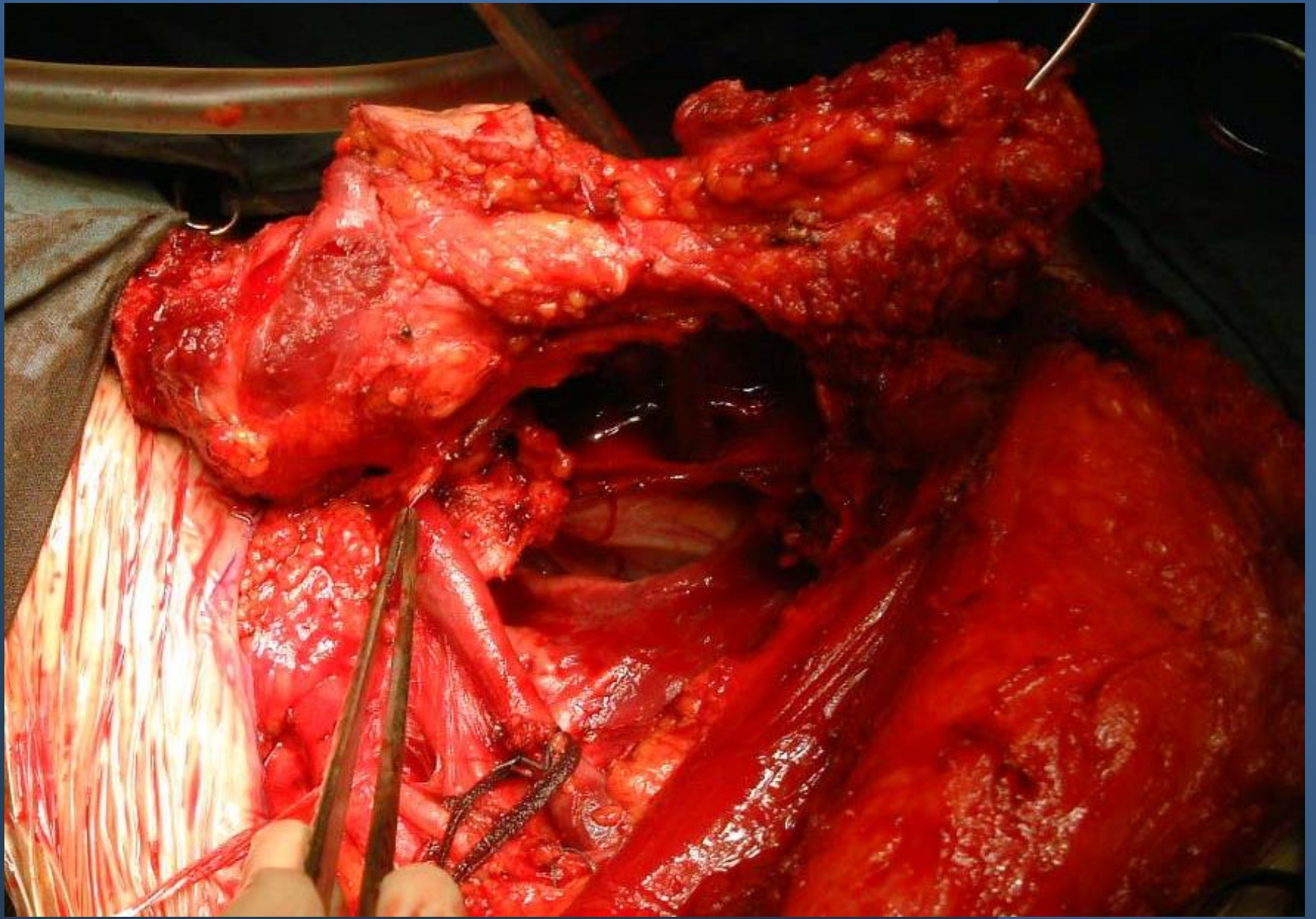


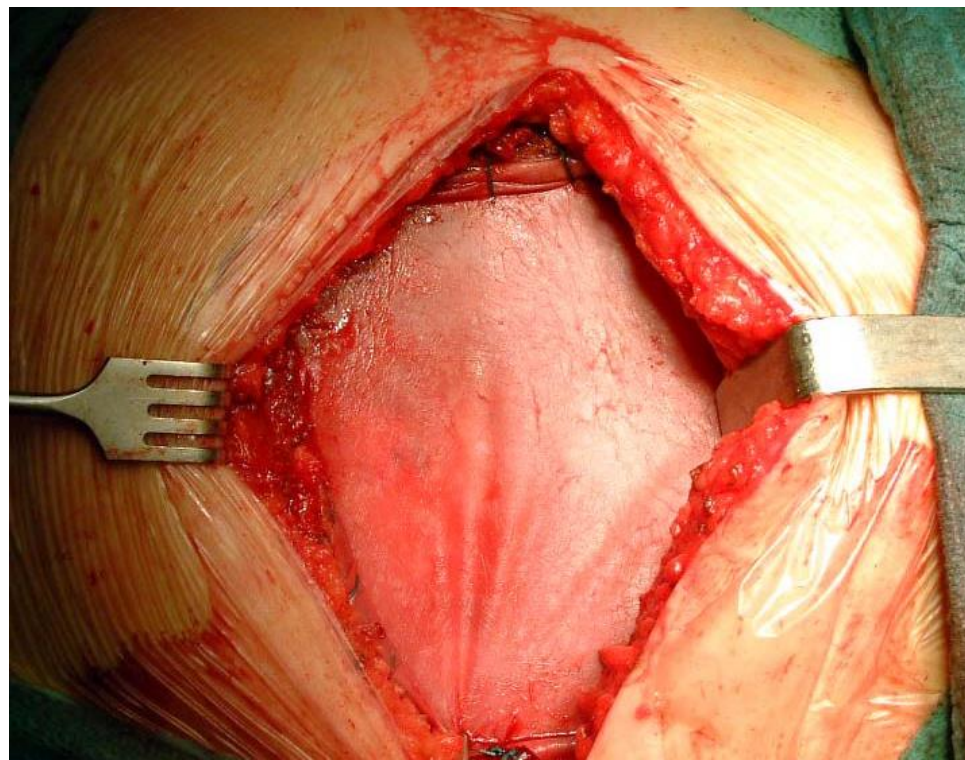
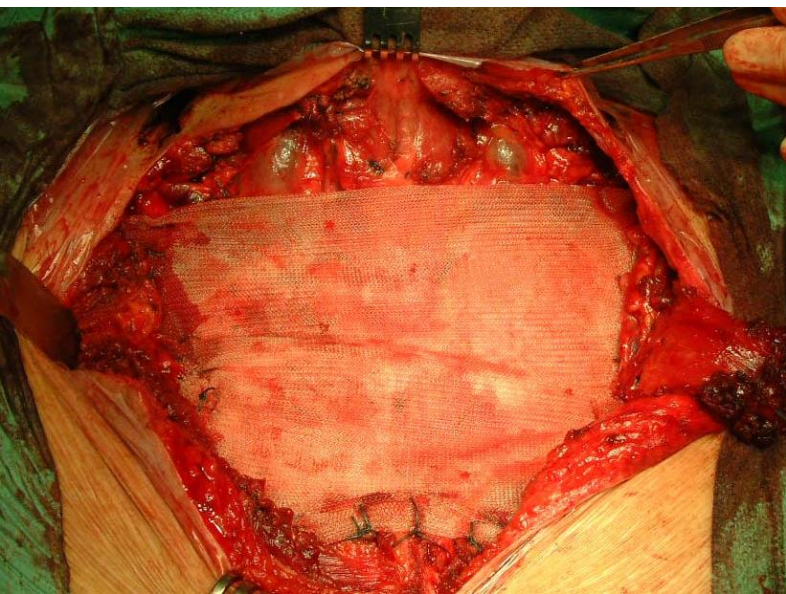
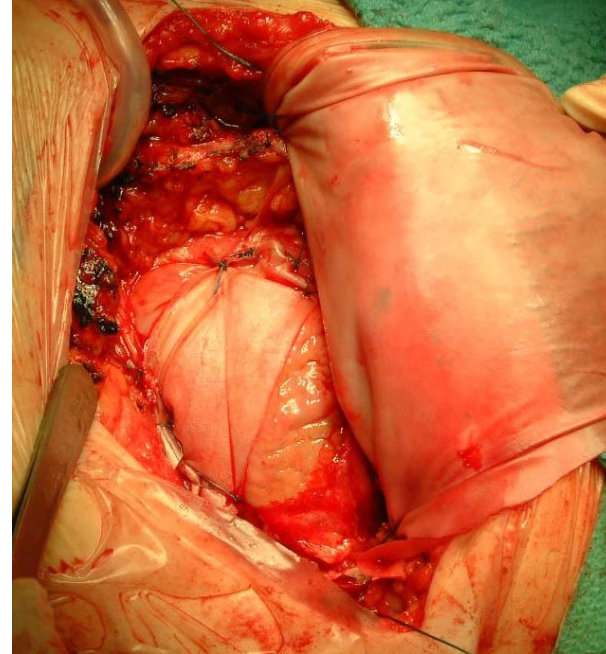
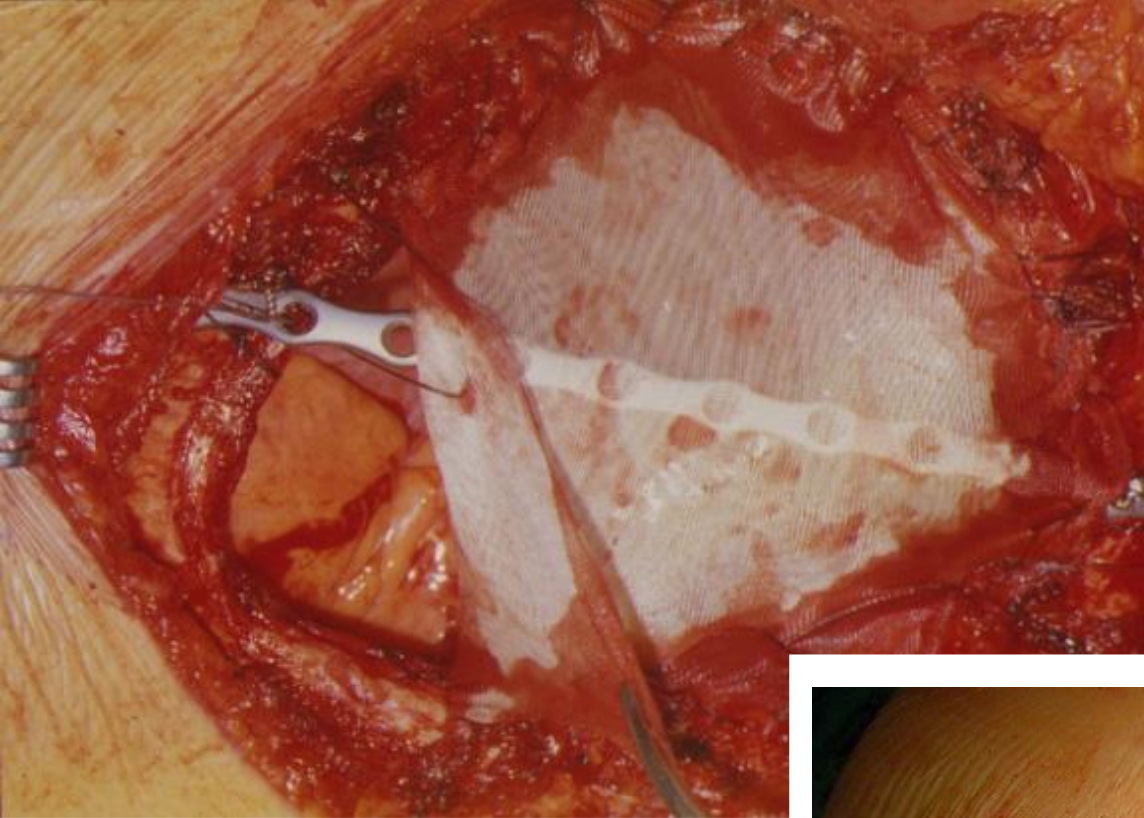
# STADIO III (T3)



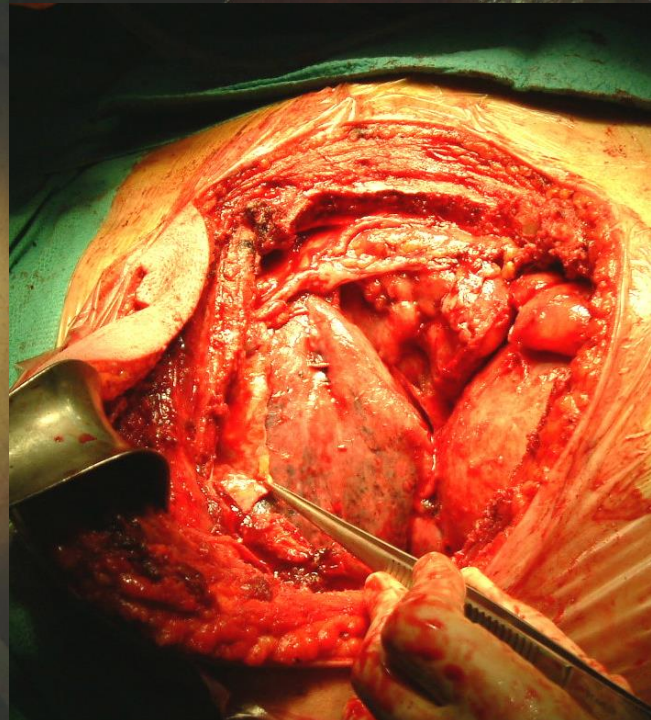
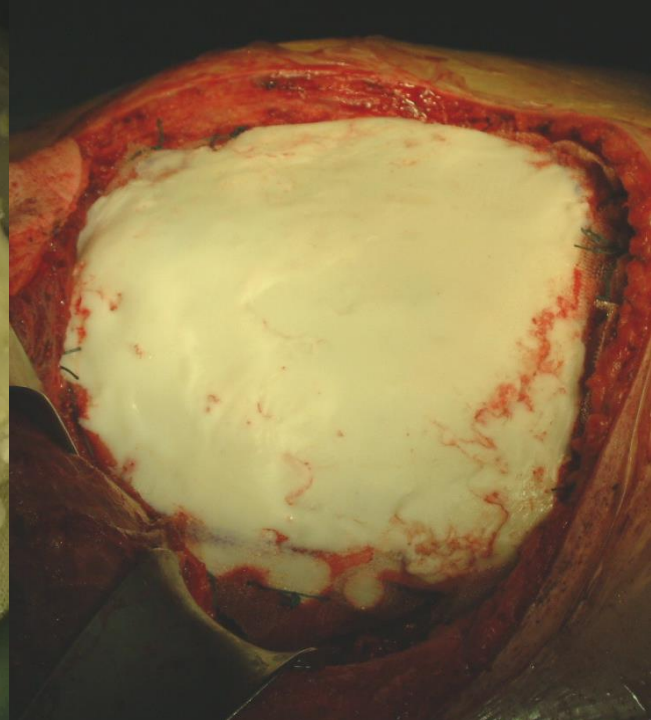
T3	Tumor >5 but ≤7 cm or invading chest wall, pericardium, phrenic nerve or separate tumor nodule(s) in the same lobe	T3 <sub>&gt;5-7</sub> T3 <sub>Inv</sub> T3 <sub>Satell</sub>
----	--	--







RESEZIONE DI PARETE  
E RICOSTRUZIONE

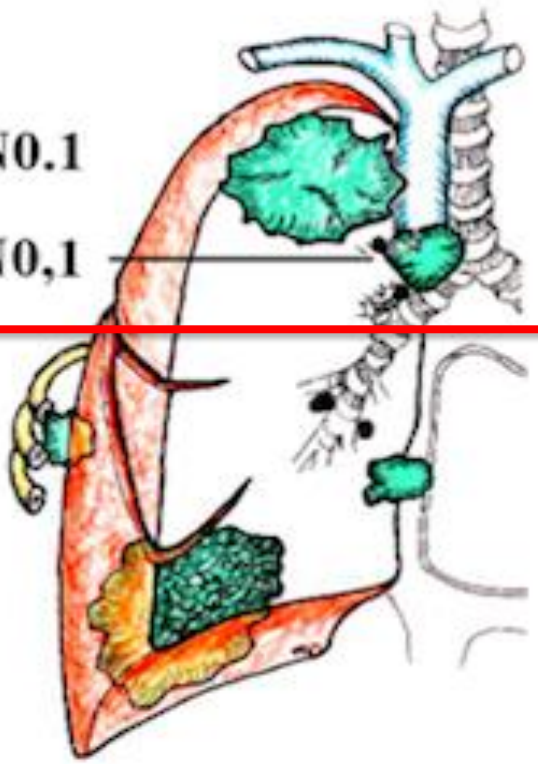


# STADIO III (T4)

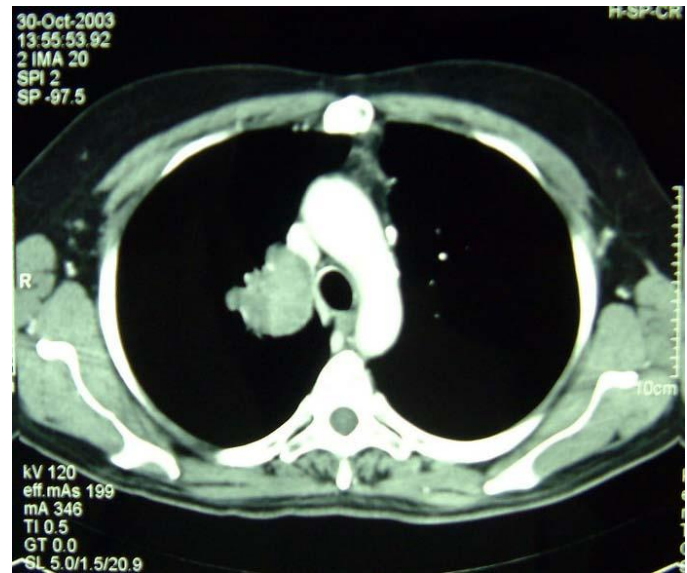
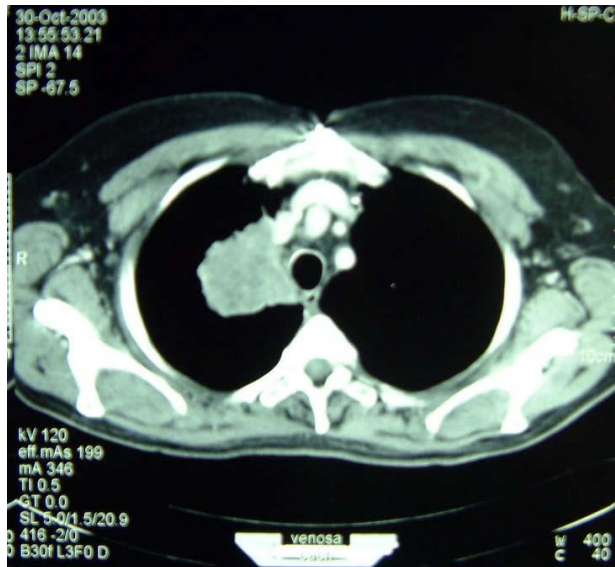
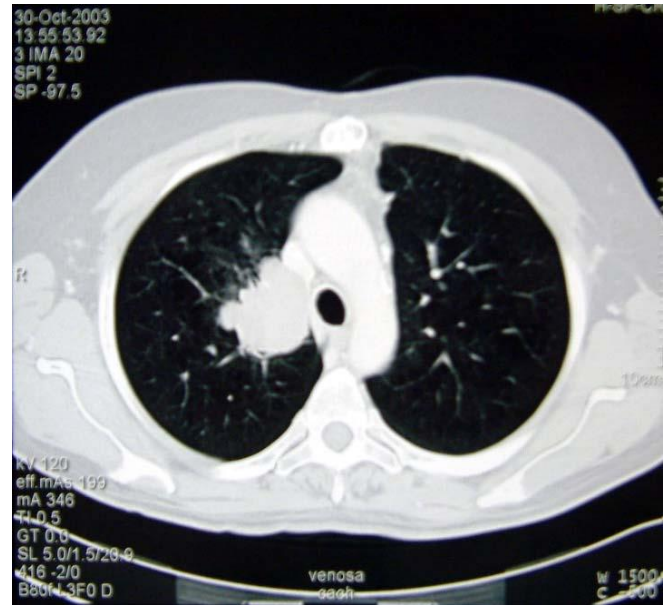
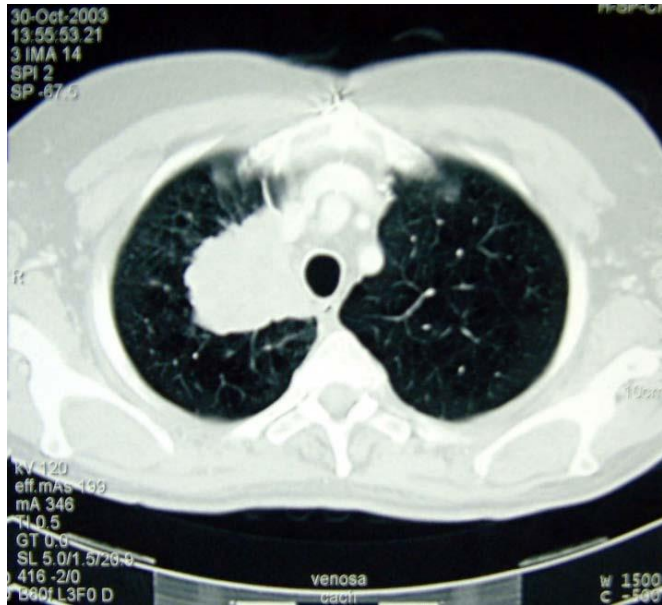
T4<sub>>7</sub> N0,1  
 T4<sub>Inv</sub> N0,1

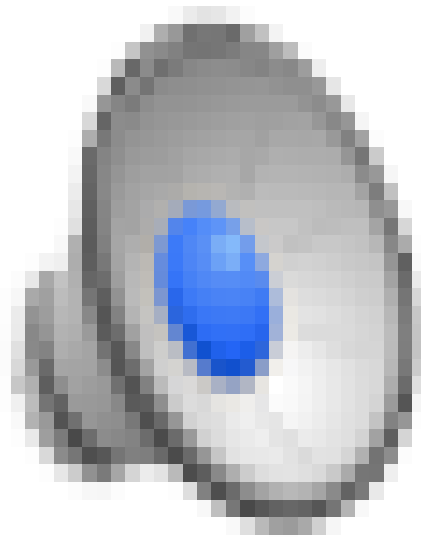
T3<sub>Inv</sub> N1

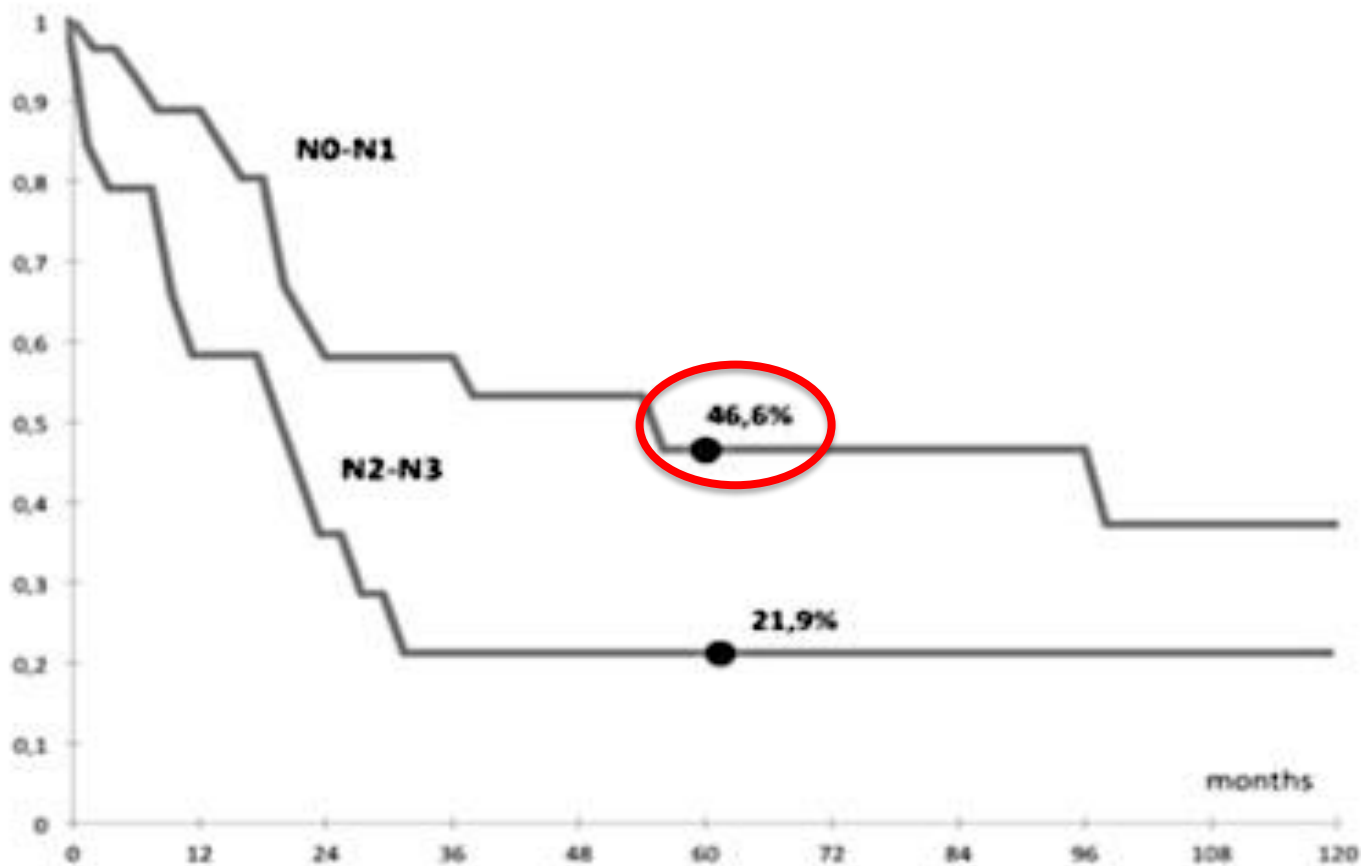
T3<sub>>5-7</sub> N1



T4	Tumor >7 cm or tumor invading: mediastinum, diaphragm, heart, great vessels, recurrent laryngeal nerve, carina, trachea, esophagus, spine; or tumor nodule(s) in a different ipsilateral lobe	T4 <sub>&gt;7</sub> T4 <sub>Inv</sub> T4 <sub>Ipsil Nod</sub>
----	---	---

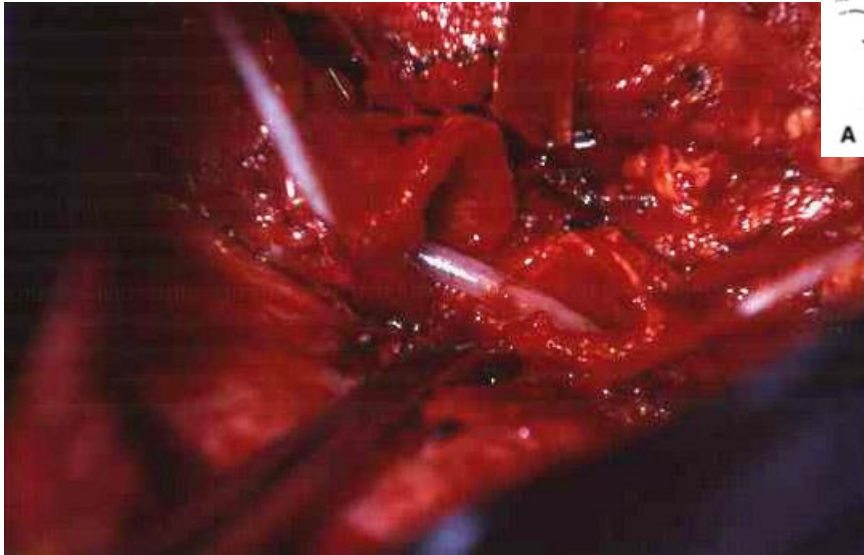
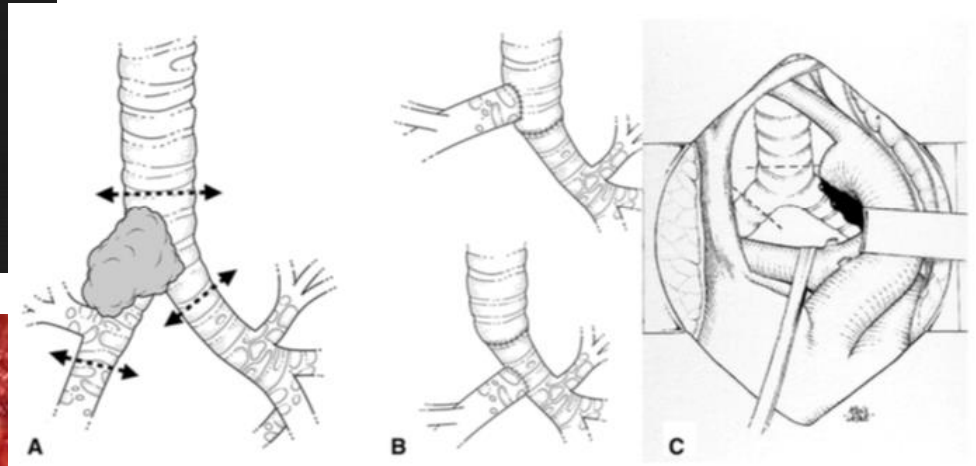
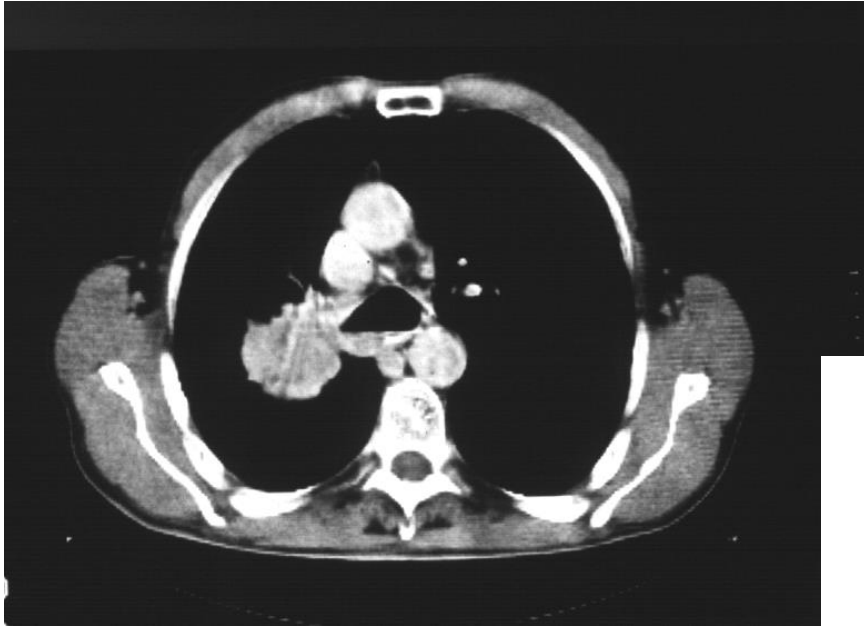




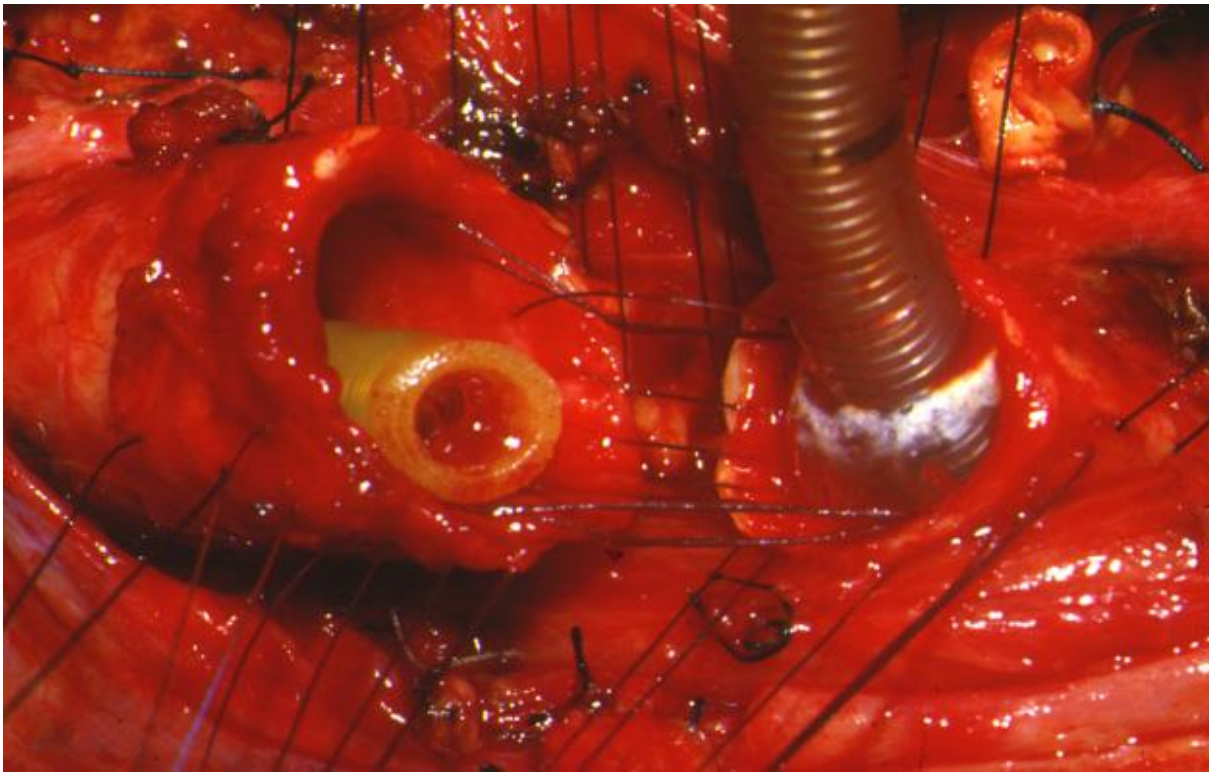


**Fig. 2** Survival curves for patients with NSCLC invading SVC according to N status

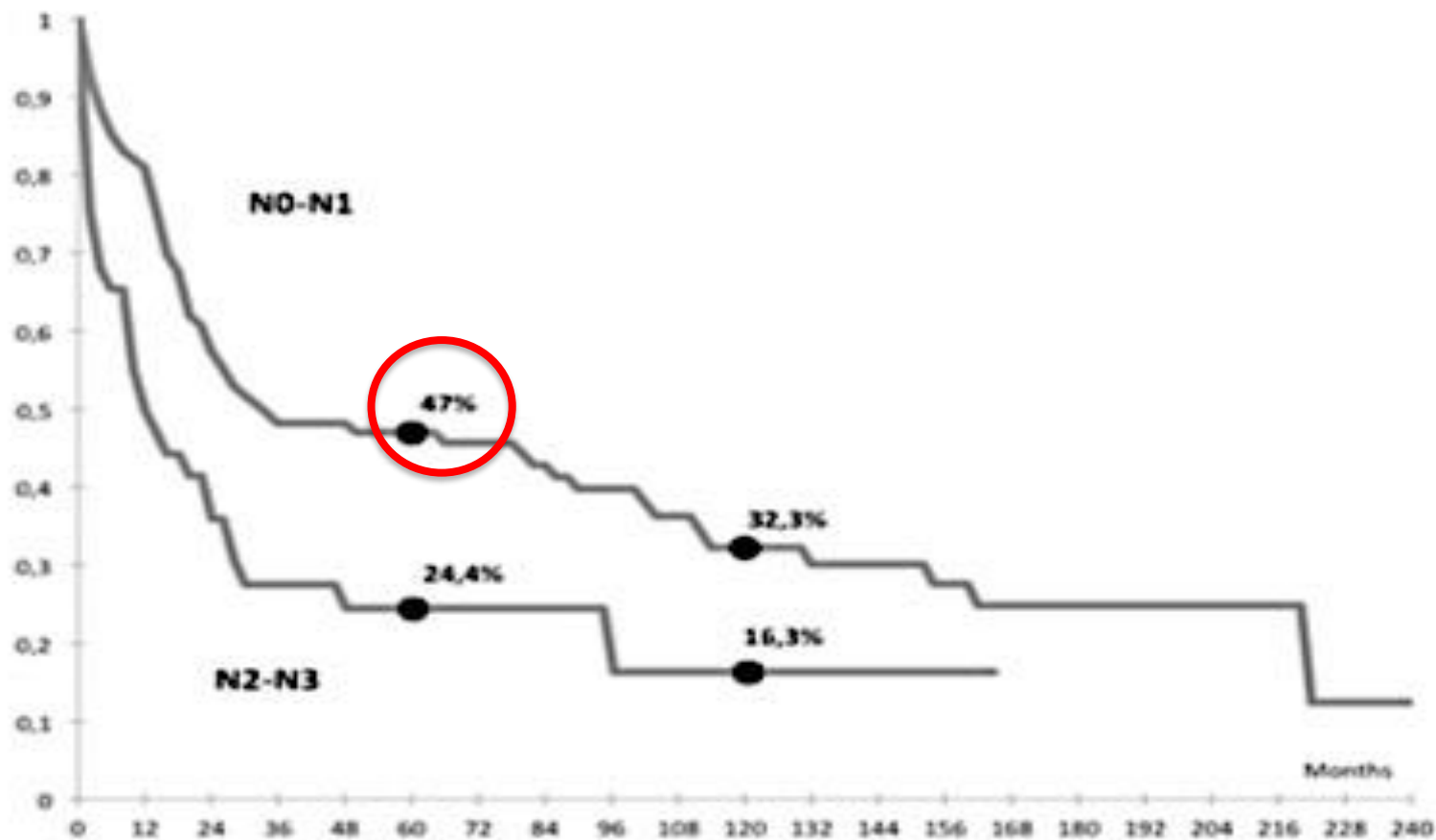
# INFILTRAZIONE DI CARENA







Controllo endoscopico a 60 gg



**Fig. 4** Survival curve for patients with NSCLC requiring carinal resection according to N status

## Extended surgery for T4 lung cancer: a 30 years' experience

P. G. Dartevelle<sup>1</sup> · D. Mitilian<sup>1</sup> · E. Fadel<sup>1</sup>

### Conclusion

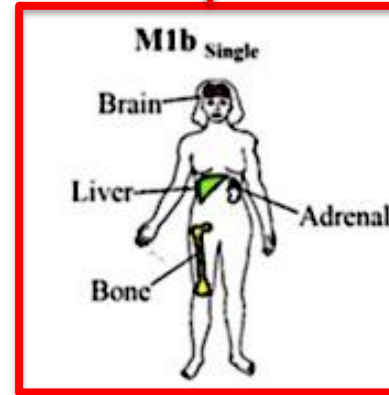
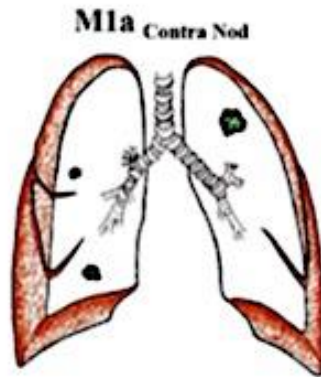
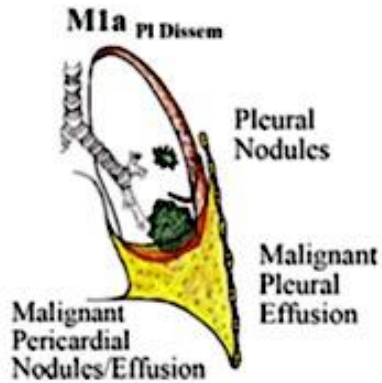
Surgery for lung cancer invading the great vessels, carina or the thoracic inlet is challenging and requires broad knowledges in cardiac and vascular surgery. However, this type of surgery in experienced hands can be performed with low mortality and promising long-term outcome in selected patients. Pre-operative staging should aim to determine whether N2 disease is present, since it carries a dismal prognosis.

CHIRURGIA COME STRUMENTO TERAPEUTICO IMPORTANTE

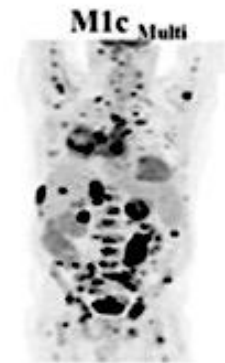
# STADIO IV (*Oligometastasi*)



## Stage IVA



## Stage IVB



**Table 1** Prognosis of oligometastases. Adapted from Niibe *et al.* (47)

Favorable	Relatively favorable	Relatively unfavorable	Unfavorable
Oligorecurrence 1 or 2 (brain and adrenal gland)	Oligorecurrence 3 to 5 (brain and adrenal gland)	3 to 5 (brain, adrenal gland, others)	>5 or polymetastases
	Sync-oligometastases 1 or 2 (brain and adrenal gland)	Sync-oligometastases 3 to 5 (brain and adrenal gland)	>5 or polymetastases



**STADIAZIONE ACCURATA**



**PIANIFICAZIONE STRATEGIA TERAPEUTICA MULTISPECIALISTICA**



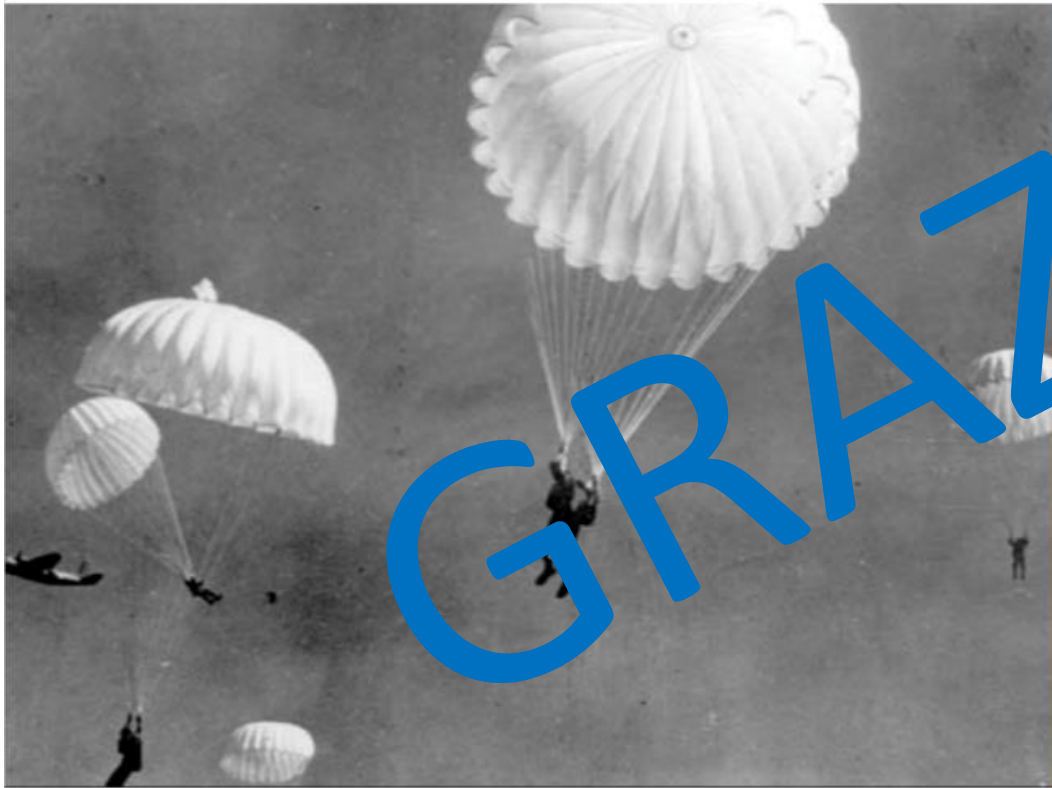
**APPROCCIO MULTIDISCIPLINARE**



**STUDI RANDOMIZZATI FUTURI**

# Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials

Gordon C S Smith, Jill P Pell



Parachutes reduce the risk of injury after gravitational challenge, but their effectiveness has not been proved with randomised controlled trials

“Parachutes reduce the risk of injury after gravitational challenge, but their effectiveness has not been proved with randomised controlled trials.”

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Gynaecology,  
Cambridge  
University,  
Cambridge  
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Public Health,  
Greater Glasgow  
NHS Board,  
Glasgow G3 8YU

Jill P Pell  
*consultant*

Correspondence to:  
G C S Smith  
gcss2@cam.ac.uk

*BMJ* 2003;327:1459–61