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Reply to the Editor:

We thank Dr Conti and colleagues¹ for their constructive comments on our report² and the Editor for giving us the opportunity to reply.

We agree with Dr Conti and colleagues' remarks; in fact, in our experience with 41 cases of tracheobronchial rupture, we treated only 6 cases surgically (3 for iatrogenic lesions during thyroid and esophageal surgery and 3 for traumatic lesions [2 with stab wounds and 1 with electric saw wounds]). Our described case was a slightly different one. With this patient, we were presented with a very difficult and somewhat delicate situation, and we resorted to a successful semiconservative treatment, which is in agreement with Conti and colleagues' remarks. Moreover in our report, even if we say "... conservative treatment is preferred for stable patients with small uncomplicated tracheobronchial lesions..." we also add that conservative treatment has been successfully described for bigger lesions. We are well aware of Conti and colleagues' experience,³ and we congratulate them, but unfortunately, the *Journal* allows only 5 references for case reports.

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A segmentectomy for stage IA non-small cell lung cancer should be associated with surgical margin cytology findings and a frozen section histologic examination of lymph nodes

To the Editor:

I enjoyed reading the article written by Nomori and colleagues.¹ Their strategy for performing a segmentectomy with little risk of local relapse included the following features: (1) Hilar and mediastinal lymph nodes are dissected as much as possible, (2) the lobectomy must be completed when metastasized cancer is found in any of the dissected lymph nodes, and (3) in nested cases with a sentinel node, frozen section histologic examinations can be limited to the sentinel lymph node.

I agree with their strategy regarding local/regional recurrence in the lymphatics. However, the crucial concept of possible local relapse is not addressed, because a relapse of non-small cell lung cancer can occur at the surgical margin, which is independent of the lymphatic system.

When complete excision has been accomplished with compromised patients with clinical stage I non-small cell lung cancer, surgical margin recurrence has been observed in approximately half of the cases with malignant cytologic results, even when the margin showed a malignant negative histology.^{2,3} Thus, a cytologic malignant positive margin in the residual lung after a segmentectomy has the potential of surgical margin relapse. On the basis of my experience with complete excisions for compromised patients, the segmentectomy should be accompanied by a surgical margin cytologic examination and frozen section histology findings of the dissected hilar and mediastinal lymph node.

I have performed 22 segmentectomies without lymph node metastasis, in which there were 2 cases (9%) with malignant

positive cytology results at the surgical margin, for which completion lobectomies were performed. If those residual lobes had been left, surgical margin relapse may have occurred, even though there was no metastasized lymph node. Thus, I recommend performing a surgical margin cytologic examination in patients who undergo a segmentectomy and in cases of excision, because malignant cytology findings have been documented in cases with malignant negative histology findings.^{4,5}

Here are some questions for Dr Nomori and colleagues: What was the status of the margin of the lung that underwent a segmentectomy? Was a margin cytologic examination carried out? Also, what options do you propose if the margin cytology were shown to be malignant positive by a cytologic method?

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We appreciate the comments by Sawabata. Sawabata and colleagues previously reported