of 79 to 85% and specificity of 90 to 91% in a meta-analysis, the assessment of nodal status by PET is not reliable in patients with microscopic nodal metastasis. Riquet (1989) reported that lung cancer metastasizes so easily to the mediastinum that selection of the patients for limited surgery should be discussed carefully. Furthermore, lung cancer has a phenomenon termed "skip metastasis" consisting of N2 disease without N1 involvement with the incidence of 20-38% in N2 patients. Therefore, lobectomy with hilar and mediastinal lymph node dissection is considered to be a basic standard procedure for lung cancer. **Differences in Survival between Sublobar Resection and Lobectomy:** Proposals of sublobar resection for clinical stage IA small-sized lung cancer less than 2 cm have been undertaken in some previous reports. Although these were non-randomized study, Okada (2001) and Koike (2003) conducted the comparative study between intentional sublobar resection and standard lobectomy in patients with tumors 20 mm or less in diameter. They showed no significant difference in survival between two groups and suggested that sublobar resection was acceptable operation for small-sized lung cancer. The significance and role of sublobar resection for subsolid tumor have become important so far. **Clinical Trials Regarding Sublobar Resection vs. Lobectomy:** Japan Clinical Oncology Group (JCOG) has conducted a cohort study (JCOG0201) evaluating correlation between radiological and pathological findings in stage I adenocarcinomas. With pathologic non-invasive adenocarcinoma defined as those with no lymph node metastasis or vessel invasion, radiological non-invasive lung adenocarcinoma was defined as those with a consolidated maximum tumor diameter to tumor diameter ratio (C/T ratio) of less than 0.5 (9). Currently, a prospective, randomized, multi-institutional phase III trial for small-sized (<=2 cm) lung cancer patients is being conducted by Cancer and Leukemia Group B (CALGB140503) to determine the effectiveness of an intentional sublobar resection for small-sized peripheral tumors. Similar phase III study (JCOG0802) is also being conducted, comparing lobectomy vs. segmentectomy for small-sized tumor with more than 0.5 C/T ratio. JCOG has already accumulated planned number of patients and now following the patients. JCOG is also conducting other two prospective multi-institutional phase II trials regarding the sublobar resection for GGO-dominant type tumors. One is JCOG0804, wide wedge resection for non-solid GGO lesion less than 2cm, and the other is JCOG1211, segmentectomy for part-solid GGO lesion with less than 0.5 C/T ratio and 2.1-3.0 cm in tumor diameter. **Sublobar Resection: Anatomic or Non-Anatomic?:** No large-scale randomized trial comparing AS with non-anatomic WR, which is technically much easier than AS, for small-sized NSCLC has been conducted so far. Despite the fact that patients undergoing AS were more likely to have nodal sampling/dissection, and more LNs retrieved than patients undergoing WR in the present study, Altoki (2017) suggested that it did not lead to an improvement in survival. This is consistent with the results of the ACOSOG Z0030 trial comparing lymph node sampling with systematic nodal dissection in patients with T1-2 N0-1 NSCLC with no difference in survival between the two groups. These findings are of interest since data from the LCSG randomized trial showed that locoregional recurrence after WR was two-fold higher than that after AS. The results that AS should be the preferred option for SR were supported by recent large population-based studies suggesting. Smith (2013) reported the results of evaluating a large population Surveillance, Epidemiology and End Result-Medicare registry (SEER) database. They found that WR were associated with inferior survival compared to AS. However, advantage of AS over WR in the SEER database is probably due to different patient selection criteria as well as inadequate wedge resections with suboptimal resection margins and insufficient or no nodal assessment. Whether WR and AS were comparable oncologic procedures for cT1N0M0 NSCLC patients or not has been still controversial issue so far. **Conclusions:** Since the clear evidence regarding the survival benefit of sublobar resection for lung cancer patient is lacking so far, lobectomy should be an appropriate therapy for medically operable lung cancer patient at the moment. Abovementioned randomized trials will clearly define the role of sublobar resection in patients with stage I patients. As the number of early-stage peripheral lung cancers is increasing, and a certain number of patients are with multifocal small lesion, the choice of surgical procedure, that is, lobectomy, AS or WR, should be tailored to each case in the future. **Keywords:** sublobar resection, lobectomy, CT screening

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Patient-Reported Outcomes with Durvalumab after Chemoradiation in Locally Advanced, Unresectable NSCLC: Data from PACIFIC

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Background: Durvalumab, an engineered human IgG1 anti-PD-L1 mAb, demonstrated an improvement in PFS vs placebo and favorable benefit/risk profile in the Phase 3 PACIFIC study in locally advanced, unresectable NSCLC. Here we summarize patient-reported outcomes from PACIFIC. **Method:** In the randomized, double-blind, Phase 3 PACIFIC study (NCT02125461), patients who had previously received ≥2 cycles of platinum-based concurrent chemotherapy with definitive dose radiation without disease progression were randomized (2:1) to durvalumab 10 mg/kg i.v. q2w or placebo for up to 12 months. Secondary endpoints included evaluation of symptoms, function and global health status/QoL using the European Organisation for Research and Treatment of Cancer (EORTC) QLQ-C30 v3 questionnaire and its lung cancer module, QLQ-LC13. Patients completed the questionnaires at baseline, Week 4, Week 8, q8w until Week 48, then q12w until disease progression. Changes from baseline for key symptoms were analyzed using a mixed model for repeated measures (MMRM). Time to deterioration (TTD) and odds of improvement were analyzed. Deterioration or improvement was defined as a change in score from baseline ≥10. Hazard ratios (HR) were calculated using a stratified log-rank test and odds ratios (OR) using logistic regression. **Result:** Compliance with completing the questionnaires was high in both durvalumab (n = 476) and placebo (n = 237) groups (>80% up to Week 48). There were no differences between groups at baseline in symptoms, function or global health status/QoL. MMRM analysis showed no statistically significant differences between treatment groups in adjusted mean changes from baseline (average over 12 months) in the prespecified symptoms of dyspnea, cough, chest pain, fatigue and appetite loss, and for global health status/QoL and physical functioning. Clinically relevant improvements from baseline were observed throughout the study in both durvalumab and placebo groups for dysphagia (mean [SD] change at Week 48, −14.2 [26.1] and −14.8 [25.3], respectively) and alopecia (−22.1 [33.0] and −21.4 [29.5]). There were no differences in median TTD between groups except 'other pain' (9.2 months with durvalumab vs 5.6 months with placebo [HR 0.72; 95% CI 0.58, 0.89]). The only difference in improvement rates between groups was for appetite loss (26.1% improvement rate with durvalumab vs 24.9% with placebo [OR 1.72; 95%CI 1.04, 2.85]). Other symptoms, function and health-related QoL remained stable throughout with no between-group differences in TTD or improvement rates. **Conclusion:** Durvalumab treatment did not worsen symptoms, function or health-related QoL. Clinically relevant improvement in alopecia and dysphagia with durvalumab and placebo was likely due to resolution of toxicities related to prior chemoradiation.