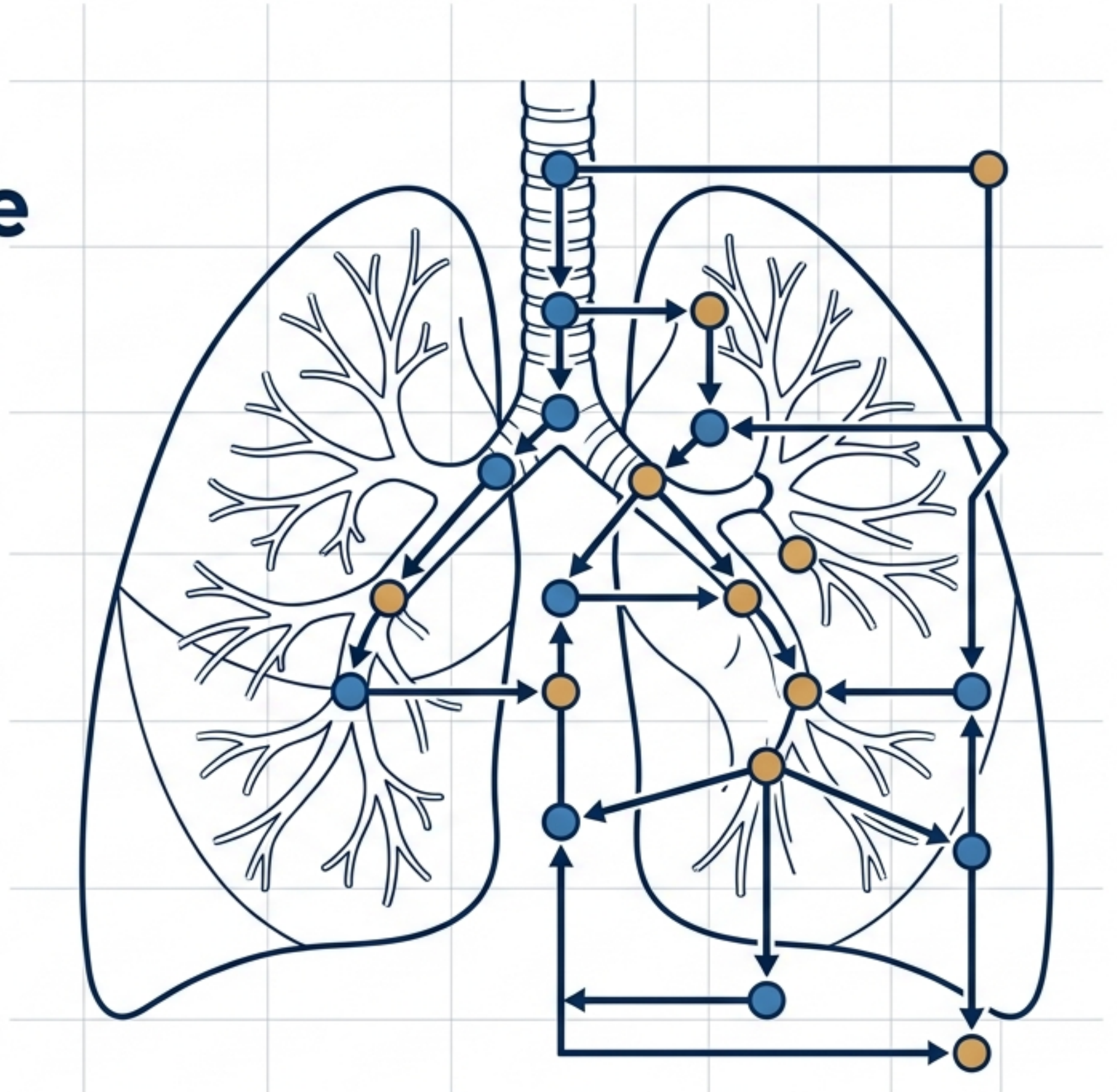


SEPAR-SECT 2026: Perioperative Invasive Mediastinal Staging in NSCLC

The Clinical Navigation Map
for the 9th Edition TNM Era

A joint consensus from the Spanish Society of
Pulmonology and Thoracic Surgery (SEPAR) and the
Spanish Society of Thoracic Surgeons (SECT).
Published in Archivos de bronconeumologia.



The Evolution of Perioperative Staging Care

2011 Standards

- Dated staging protocols
- Strictly preoperative focus
- Generic surgical interventions

Structured literature review & multidisciplinary expert consensus

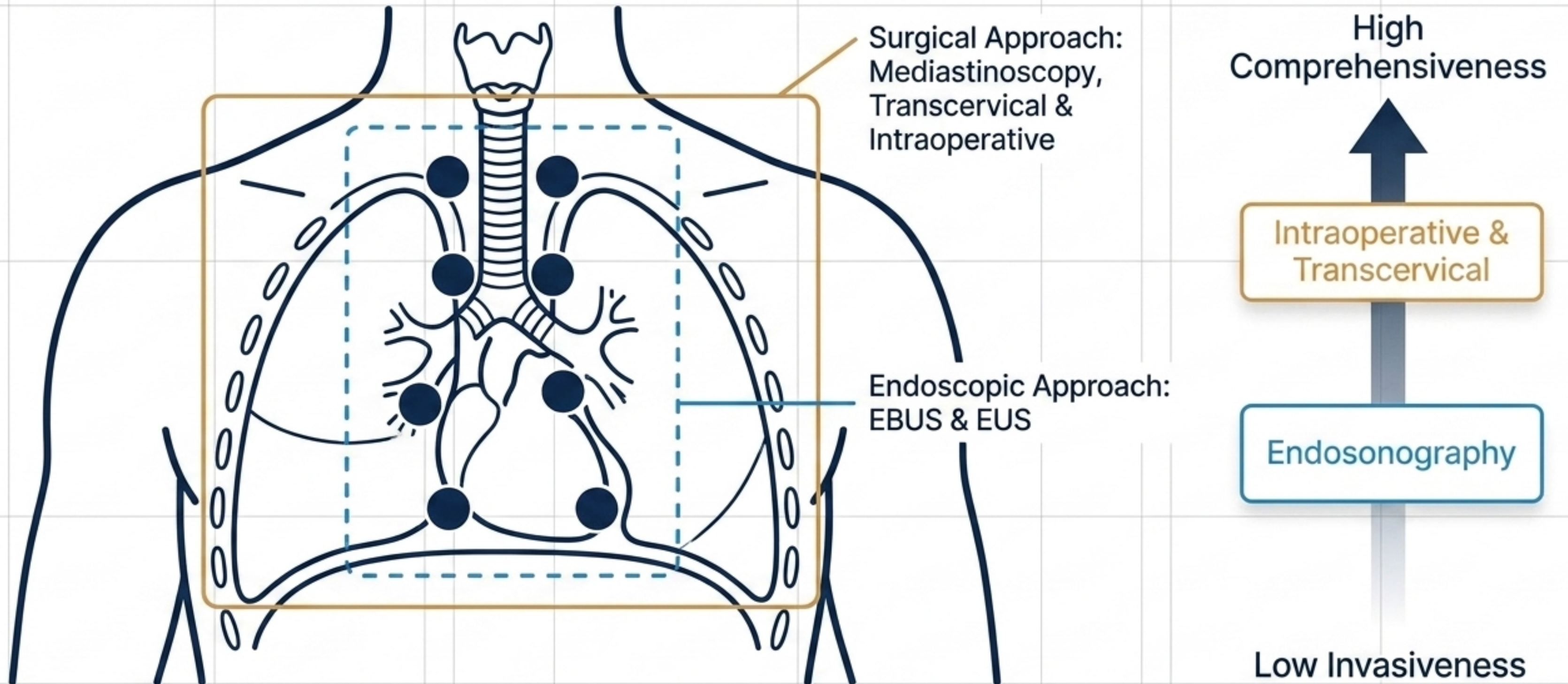


2026 SEPAR-SECT Standards

- Full integration of 9th edition TNM classification
- Extended to the entire perioperative setting (pre & intraoperative)
- Foundation for targeted and immune-based treatments

Accurate staging is no longer just prognostic; it is the absolute prerequisite for precise multimodal therapeutic decision-making.

Anatomical Targeting Map: The Staging Toolkit



Comparing Modalities: Endosonography vs. Surgical Staging

Dimension	Endosonography (EBUS/EUS)	Surgical Staging
Invasiveness	Low, minimally invasive	Moderate/High, surgical environment
Primary Indication	Initial tissue sampling, accessible central nodes	Comprehensive evaluation, structural validation
Diagnostic Accuracy in Intermediate Suspicion	Limited by sampling error	Superior accuracy, definitive structural confirmation
Role in Perioperative Setting	Preoperative baseline	Preoperative escalation & Intraoperative final staging

Key Insight: Surgical staging remains an indispensable tool, specifically where endosonography hits diagnostic ceilings.

Assessing the Risk of Occult Mediastinal Disease



The 2026 guidelines dictate that the staging algorithm must dynamically adapt to these variables to minimize both understaging and overstaging.

The 2026 Clinical Stratification Profiles

Low Risk

Profile: T1a and T1b tumours

Condition: No radiological evidence of nodal disease (regardless of location)

Directive: Escalate directly to definitive therapy.

Intermediate Risk

Profile: Intermediate suspicion of mediastinal disease.

Condition: Ambiguous imaging or clinical features

Directive: Requires advanced surgical staging due to accuracy limits of endosonography.

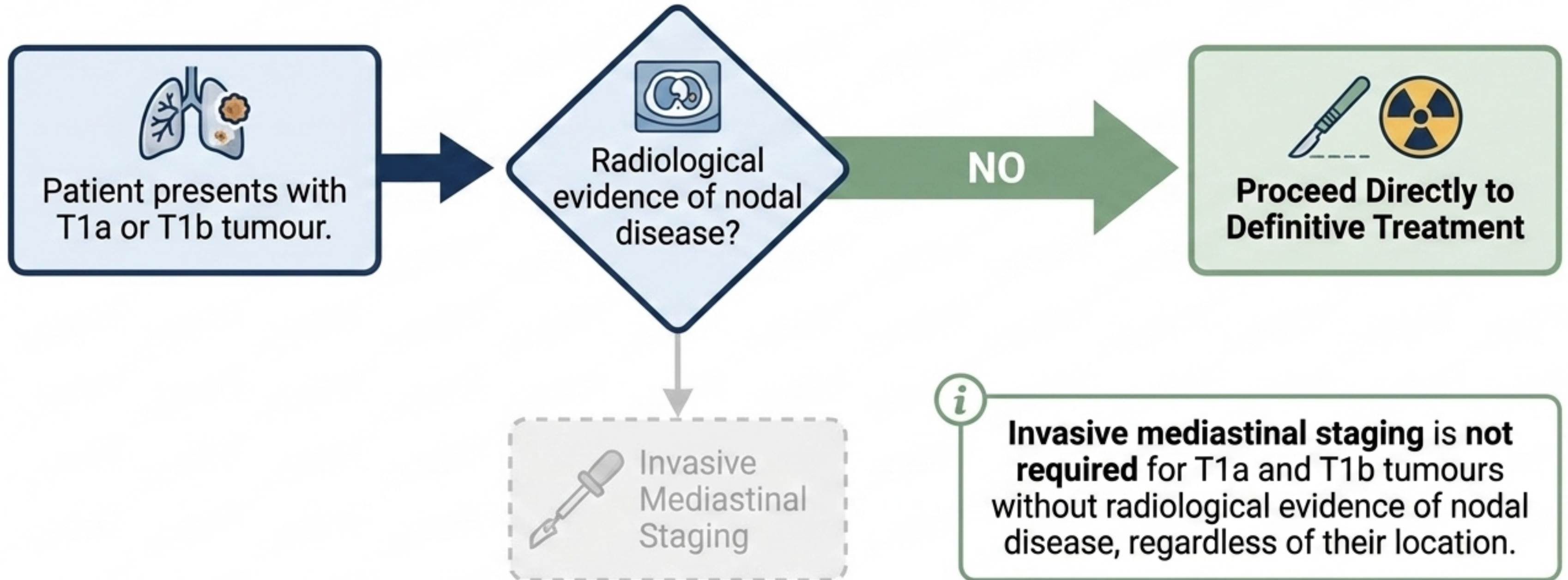
High Risk

Profile: N1 Disease

Condition: Suspected or confirmed N1 involvement

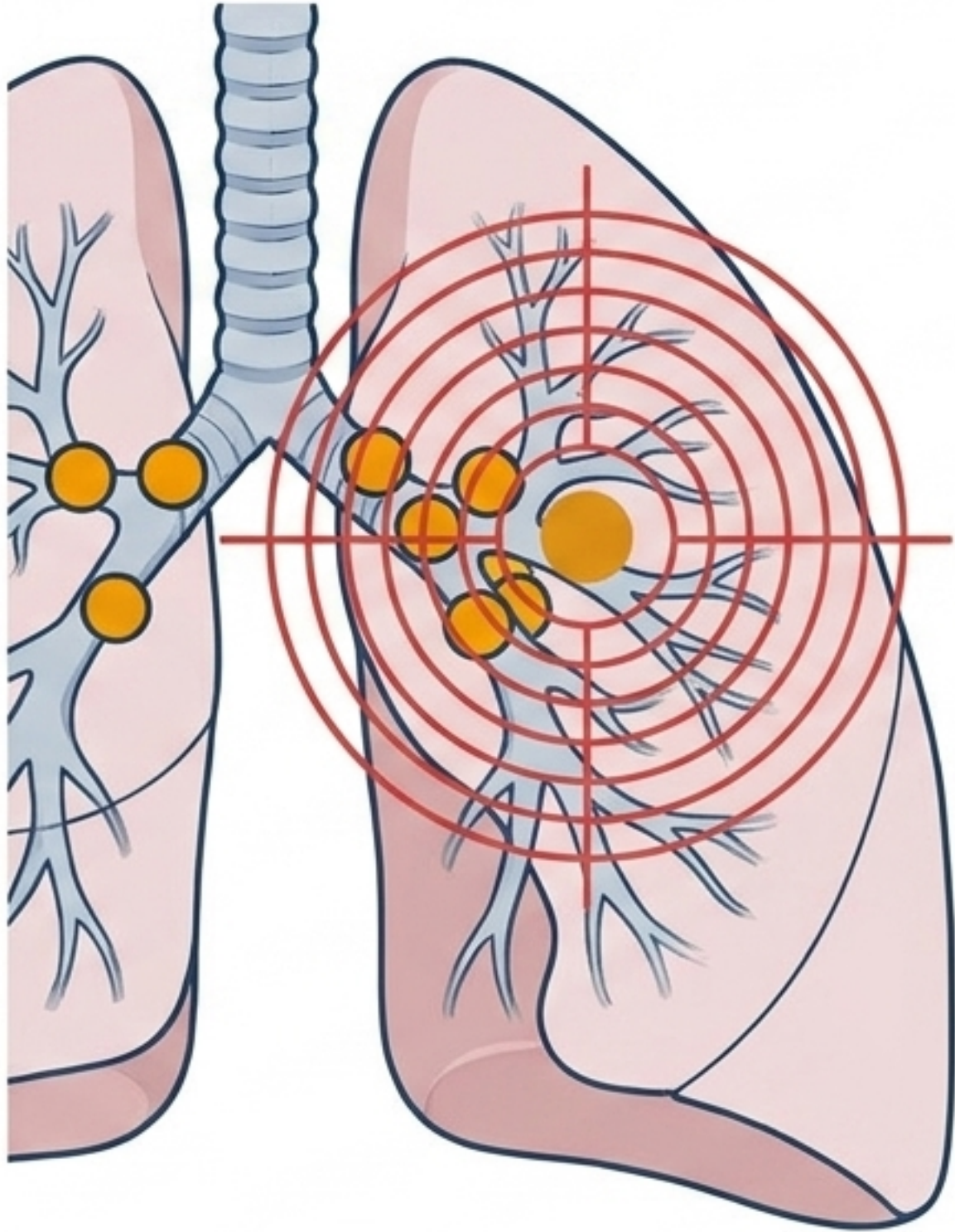
Directive: Mandates rigorous attention; extremely high risk for unsuspected mediastinal disease

Pathway 1: The Low-Risk Exemption



Impact: Eliminates unnecessary procedures, streamlining the path to definitive treatment and minimizing overstaging.

Pathway 2: The High-Risk N1 Flag



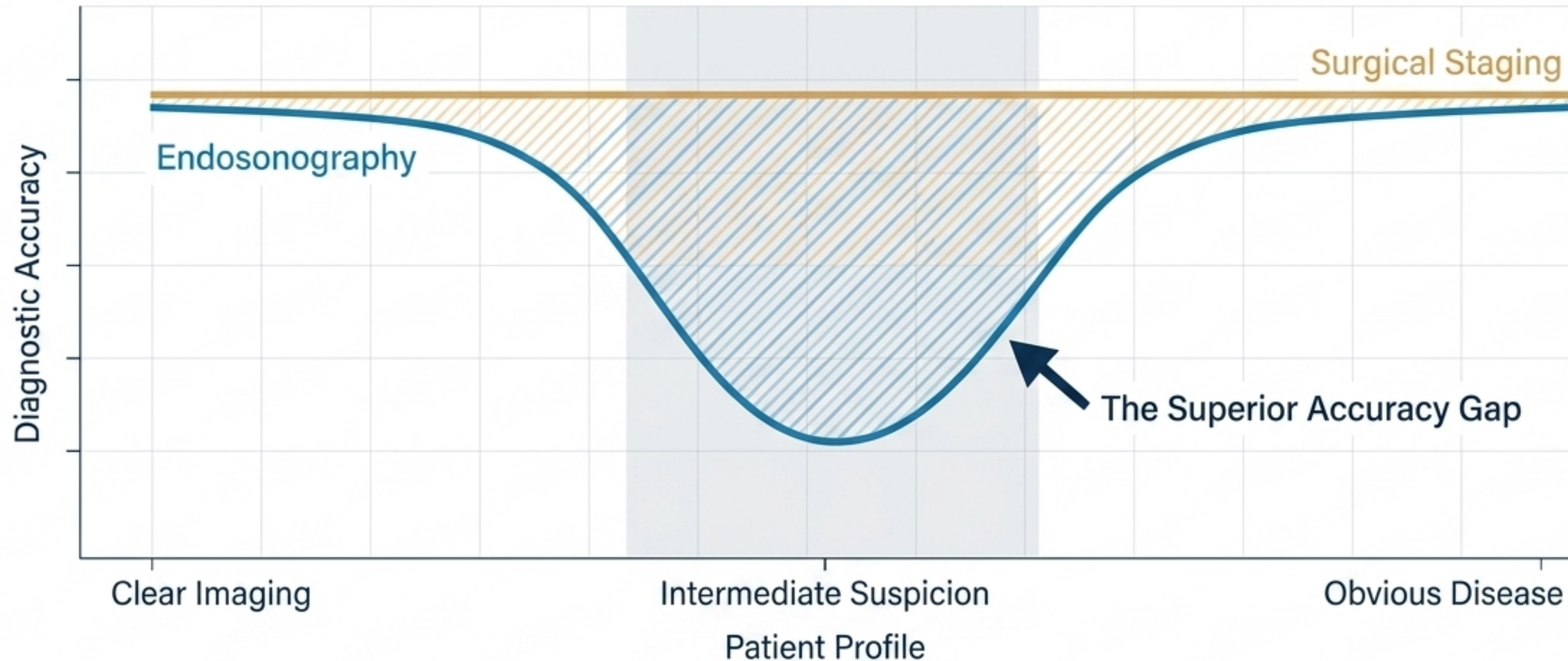
N1 Disease = Critical Warning Flag

- Particular attention is mandated by the 2026 guidelines for any N1 involvement.
- Now formally recognized as a setting associated with a high risk of unsuspected mediastinal involvement.
- Cannot rely on baseline imaging alone; requires aggressive staging validation to prevent catastrophic understaging.



Action: Comprehensive Invasive Mediastinal Staging Required.

Pathway 3: Intermediate Suspicion & The Accuracy Gap



For cases with intermediate suspicion of mediastinal disease, surgical staging techniques demonstrate superior accuracy compared with endosonography alone.

Intraoperative Quality Standards & Resection Completeness



Full integration of the International Association for the Study of Lung Cancer (IASLC) definitions of completeness of resection

The Surgical Standard Checklist



Systematic nodal evaluation is mandatory during surgery



Routine intraoperative lymphadenectomy serves as the definitive final staging step



Strict adherence to formalized SEPAR-SECT intraoperative quality metrics

Preoperative staging guides the strategy; intraoperative staging guarantees the standard of care

The Precision Ecosystem



Invasive staging is no longer just a diagnostic box to check—it is the foundational keystone of modern, personalized NSCLC oncology. Harmonized practice across disciplines unlocks the full potential of multimodal care.