The postoperative neutrophil-to-lymphocyte ratio and changes in this ratio predict survival after the complete resection of stage I non-small cell lung cancer

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Purpose: Although numerous studies have demonstrated associations between the preoperative neutrophil-to-lymphocyte ratio (NLR) and long-term outcomes in patients with non-small cell lung cancer (NSCLC), the prognostic significance of postoperative NLR and change in NLR (∆NLR) is unknown for patients who underwent complete resection of stage I NSCLC. The aim of this retrospective study was to evaluate the prognostic significance of postoperative NLR and ∆NLR in 123 patients with stage I NSCLC.

Patients and methods: This retrospective study included preoperative and postoperative data of 123 patients who underwent surgical resection for stage I NSCLC. The relationship between disease-free survival (DFS), overall survival (OS), and clinicopathological factors, including NLR, lymphocyte-to-monocyte ratio (LMR), platelet-to-lymphocyte ratio, and their changes, was analyzed using both univariate Kaplan–Meier and multivariate Cox regression methods.

Results: The 5-year DFS and OS rates in our cohort were 60.16% and 67.48%, respectively. Univariate analysis revealed that age (P=0.045), smoking status (P=0.033), preoperative NLR (P=0.032), postoperative NLR (P<0.001), ∆NLR (P=0.004), and change in LMR (∆LMR) (P=0.025) were significant predictors of DFS and that age (P=0.039), smoking status (P=0.042), postoperative NLR (P<0.001), ∆NLR (P=0.004), and ∆LMR (P=0.011) were independent predictors of OS. Multivariate analysis confirmed that postoperative NLR (hazard ratio [HR]=2.435, P=0.001) and ∆NLR (HR=2.103, P=0.012) were independent predictors of DFS and that postoperative NLR (HR=2.747, P=0.001) and ∆NLR (HR=2.052, P=0.018) were significant prognostic factors of OS.

Conclusion: Our study reported for the first time that postoperative NLR and ∆NLR – but not preoperative NLR – were independent prognostic factors of DFS and OS in patients with stage I NSCLC who underwent complete resection. This easily available biomarker might be helpful in individual risk assessment.

Keywords: neutrophil-to-lymphocyte ratio, non-small-cell lung cancer, stage I, prognosis, surgery

Introduction

Lung cancer is the second most common newly diagnosed cancer and one of the leading causes of cancer-related death among both men and women worldwide.¹ Surgical resection is the treatment of choice for patients with early-stage non-small cell lung cancer (NSCLC).² Despite aggressive surgical therapy, ~30%–40% of patients with...
stage I NSCLC develop tumor recurrence in a short time. Therefore, a reliable and inexpensive biomarker is needed to predict survival in patients with NSCLC and identify the subgroups of patients who will benefit from aggressive postoperative treatment.

Recently, a systemic inflammatory marker for prognosis, the neutrophil-to-lymphocyte ratio (NLR), has received considerable interest because it is simple, convenient, and inexpensive. Although numerous studies have demonstrated associations between preoperative NLR and outcomes in primary operable patients with NSCLC, other studies have concluded the opposite. Moreover, some studies found that postoperative NLR could predict the survival of patients with hepatocellular carcinoma, colorectal cancer, and bladder cancer after complete resection. These results suggest that postoperative NLR might provide a more precise reflection of the balance between tumor inflammatory response and host immune response.

The change in NLR (ΔNLR) represents the balance between protumor inflammatory response and antitumor immune response after the surgical removal of the tumor, which may affect prognosis. Some studies have found that ΔNLR is a useful prognostic predictor in patients with hepatocellular carcinoma. However, the prognostic significance of postoperative NLR and ΔNLR is unknown for patients undergoing complete resection of stage I NSCLC.

Accordingly, the aim of this retrospective study was to evaluate the prognostic significance of postoperative NLR and ΔNLR in patients with stage I NSCLCs that were treated with complete resection.

**Patients and methods**

**Patient cohort**

This was a retrospective study of patients with stage I NSCLC who underwent complete pulmonary resection (lobectomy or pneumonectomy) and systematic dissection of the hilar and mediastinal lymph nodes between January 2007 and December 2010 at the Shandong Cancer Hospital and Institute (Jinan, China). The exclusion criteria were as follows: chemotherapy or radiotherapy before the surgery; recurrence; clinical evidence of preoperative or postoperative infection or other bone marrow disorders; intraoperative or postoperative complications; recent steroid therapy; intraoperative or postoperative blood transfusion; hematological or autoimmune disease; history of another type of cancer; and a second primary cancer diagnosed within 5 years. All patients received chemotherapy with or without radiotherapy after recurrence. After applying the criteria mentioned earlier, 123 patients with stage I NSCLC were recruited for this study. All of the clinicopathological data were retrieved from medical records.

The preoperative evaluation included a detailed clinical history, physical examination, blood chemistry analysis, flexible bronchoscopy, chest and upper abdominal computed tomography, radionuclide bone scan, and brain magnetic resonance imaging. The histological diagnosis of NSCLC was based on the criteria of the revised World Health Organization classification of lung tumors and tumor staging (7th edition) and the TNM classification (T, tumor size; N, involvement of lymph nodes; M, distant metastasis). This study was approved by the Ethics Committee of Shandong Cancer Hospital and Institute, Jinan, China, and written informed consent was obtained from each participant in accordance with institutional guidelines. All treatments were carried out in accordance with the approved guidelines and regulations.

All 123 patients were regularly followed up at 3-month intervals for the first 2 years after surgery, every 6 months during the following year, and annually thereafter. The complete follow-up information was recorded, including the findings of physical examinations, chest computed tomography, abdominal ultrasound, and blood analyses (including serum tumor markers). The last date of follow-up occurred at the end of October 2015.

**Definition of inflammatory markers and survival**

Peripheral venous blood samples were collected between 8 am and 10 am within 1 week before surgery and at least 1 month after surgery. The NLR was determined from the differential count by dividing the absolute neutrophil count by the absolute lymphocyte count. ΔNLR was calculated as postoperative NLR minus preoperative NLR. The lymphocyte-to-monocyte ratio (LMR), platelet-to-lymphocyte ratio (PLR), and their changes (change in LMR [ΔLMR] and change in PLR [ΔPLR]) were calculated in a similar manner. The overall survival (OS) time was defined as the interval between the operation and death or the last follow-up. The disease-free survival (DFS) time was defined as the interval between the operation and the first incidence of detectable recurrence. Patients who remained disease free or alive were censored at the final follow-up. DFS and OS were used to demonstrate the prognostic values of inflammatory markers.

**Statistical analysis**

All statistical analyses were conducted using SPSS for Windows, version 20.0 (IBM Corporation, Armonk, NY, USA). Pretreatment and posttreatment inflammatory markers, including NLR, LMR, PLR, and their changes (ΔNLR, ΔLMR, and ΔPLR), were entered into the univariate and multivariate
analyses to identify the associations with DFS and OS. To determine the optimal cutoff value for each inflammatory marker, a receiver operating characteristic (ROC) curve was generated, and the cutoff value was defined as the point on the curve that was closest to the upper left-hand corner of the plot. According to previously published study, the median age of the study cohort was used as a cutoff value for age. DFS and OS rates were estimated using the Kaplan–Meier method, and log-rank tests were used for the univariate analysis. Variables that showed significant associations in the univariate analysis (P<0.05) were included in a multivariate stepwise backward Cox regression model to validate their independent prognostic values. Differences were assumed to be significant when a P-value of <0.05 was achieved.

**Results**

**Baseline characteristics**

A total of 123 consecutive patients with complete medical information and follow-up data were included in the analysis. The baseline characteristics of the patients are presented in Table 1. The study cohort included 94 men (76.42%) and 29 women (23.58%), with a median age of 62 years (range: 39–81 years). The numbers of patients with Eastern Cooperative Oncology Group scores of 0 and 1 (considered good) were 79 (64.23%) and 39 (31.71%), respectively. Seventy-three (59.35%) patients had a history of smoking. Sixty (60%) patients had adenocarcinoma, 49 (39.84%) patients had squamous cell carcinoma, and 14 (11.38%) patients had other histologies. Ninety-eight (79.67%) patients had a well or moderately differentiated histology, and 63 (51.22%) patients were of stage IA disease. Of the 123 patients, 104 (84.55%) patients underwent a lobectomy and 19 (15.45%) patients underwent a pneumonectomy. The median follow-up time was 69 months (range: 9–107 months). The details of treatment after recurrence are as follows: all relapsed patients received more than four cycles of platinum-based chemotherapy, 38 patients received thoracic radiotherapy; 20 patients received brain metastases radiotherapy, and 11 patients received bone metastases radiotherapy. There were 49 patients of recurrence, 40 deaths, and 83 patients who were alive at the time of the final follow-up. The 5-year DFS and OS rates were 60.16% and 67.48%, respectively. The patients exhibited a median preoperative NLR of 2.3 (range: 0.87–10.07), a median postoperative NLR of 3.94 (range: 0.54–15.11), and a median ∆NLR of 1.9 (range: -7.97 to 12.86). All of the inflammation markers that were calculated from blood cell counts are summarized in Table 2.

**Table 1 Baseline characteristics of the 123 patients**

| Clinical feature       | N   | Percentage |
|------------------------|-----|------------|
| Sex                    |     |            |
| Male                   | 94  | 76.42      |
| Female                 | 29  | 23.58      |
| Age (median), years    |     |            |
| ≤62                    | 62  | 50.41      |
| >62                    | 61  | 49.59      |
| ECOG scores            |     |            |
| 0                      | 79  | 64.23      |
| 1                      | 39  | 31.71      |
| ≥2                     | 5   | 4.06       |
| Smoking status         |     |            |
| Yes                    | 73  | 59.35      |
| No                     | 50  | 40.65      |
| Histological subtype   |     |            |
| Adenocarcinoma         | 60  | 48.78      |
| Squamous carcinoma     | 49  | 39.84      |
| Others                 | 14  | 11.38      |
| Differentiation        |     |            |
| Well/moderate          | 98  | 79.67      |
| Poor                   | 25  | 20.33      |
| Pathological stage     |     |            |
| Stage IA               | 63  | 51.22      |
| Stage IB               | 60  | 48.78      |
| Tumor location         |     |            |
| Left                   | 50  | 40.65      |
| Right                  | 73  | 59.35      |
| Surgical procedures    |     |            |
| Lobectomy              | 104 | 84.55      |
| Pneumonectomy          | 19  | 15.45      |

**Table 2 Inflammation markers of the 123 patients**

| Variable       | Median (range) |
|----------------|----------------|
| NLR            |                |
| Preoperative   | 22.3 (0.87 to 10.07) |
| Postoperative  | 33.94 (0.54 to 15.11) |
| ∆NLR           | 1.9 (−7.97 to 12.86) |
| LMR            |                |
| Preoperative   | 33.7 (0.95 to 15.25) |
| Postoperative  | 2.16 (0.61 to 25.5) |
| ∆LMR           | −1.53 (−13.42 to 21.06) |
| PLR            |                |
| Preoperative   | 108.26 (31.32 to 270.53) |
| Postoperative  | 1,161.67 (41.95 to 608.74) |
| ∆PLR           | 557.85 (−136.09 to 369.58) |

**Abbreviations:** LMR, lymphocyte-to-monocyte ratio; ∆LMR, change in LMR; NLR, neutrophil-to-lymphocyte ratio; ∆NLR, change in NLR; PLR, platelet-to-lymphocyte ratio; ∆PLR, change in PLR.
and a specificity of 62.2% for predicting recurrence. The best cutoff values for postoperative NLR and ΔNLR were 3.9 and 1.5, respectively, with AUCs of 0.75 (sensitivity: 67.3%, specificity: 70.3%) and 0.716 (sensitivity: 71.4%, specificity: 69.3%), respectively (Figure 1). The AUCs for preoperative LMR, postoperative LMR, ΔLMR, preoperative PLR, postoperative PLR, and ΔPLR were 0.534, 0.467, 0.428, 0.559, 0.358, and 0.445, respectively. The selected cutoff values for preoperative LMR, postoperative LMR, ΔLMR, preoperative PLR, postoperative PLR, and ΔPLR were 2.9, 2.6, −1.5, 100, 144, and 24, respectively.

### Inflammatory markers and survival

Univariate analysis revealed that age ($P=0.045$), smoking status ($P=0.033$), preoperative NLR ($P=0.032$), postoperative NLR ($P<0.001$), ΔNLR ($P=0.004$), and ΔLMR ($P=0.025$) were significant predictors of DFS (Tables 3 and 4) and that age ($P=0.039$), smoking status ($P=0.042$), postoperative NLR ($P<0.001$), ΔNLR ($P=0.004$), and ΔLMR ($P=0.011$) were prognostic factors of OS (Tables 3 and 4). Preoperative LMR, postoperative LMR, preoperative PLR, postoperative PLR, and ΔPLR did not predict DFS or OS after surgery.

**Table 3** Univariate Kaplan–Meier analysis of DFS and OS according to baseline characteristics

| Factor                  | DFS                  | OS       |
|-------------------------|----------------------|----------|
|                         | Median (months)      | 95% CI   | P-value | Median (months)   | 95% CI   | P-value |
| Sex                     |                      |          |         |                    |          |        |
| Male                    | 63                   | 56.955–69.045 | 0.323   | 66                 | 60.884–71.116 | 0.376   |
| Female                  | 69                   | 67.022–70.978 | 69   | 66.74–71.26      |          | |
| Age, years              |                      |          |         |                    |          |        |
| ≤62                     | 69                   | 63.599–74.401 | 0.045   | 71                 | 66.202–75.798 | 0.039   |
| >62                     | 61                   | 50.418–71.582 | 66   | 59.023–72.977 |          |        |
| ECOG                    |                      |          |         |                    |          |        |
| 0                       | 68                   | 62.741–73.259 | 0.413   | 69                 | 65.495–72.505 | 0.51    |
| 1                       | 66                   | 60.822–71.178 |       | 66                 | 61.469–70.531 |        |
| ≥2                      | 29                   | 0–65.5   | 0.033   | 54                 | 30.382–77.618 | 0.042   |
| Smoking status          |                      |          |         |                    |          |        |
| Yes                     | 62                   | 50.363–73.637 |       | 66                 | 59.348–72.652 | 0.967   |
| No                      | 69                   | 65.904–75.096 |       | 69                 | 65.008–74.992 |        |
| Histological subtype    |                      |          |         |                    |          |        |
| Adenocarcinoma          | 66                   | 60.581–71.419 | 0.571   | 67                 | 63.628–70.372 | 0.626   |
| Squamous                | 67                   | 54.655–79.345 |       | 69                 | 63.522–74.478 |        |
| Others                  | 69                   | 67.185–70.815 |       | 69                 | 54.333–83.667 |        |
| Differentiation         |                      |          |         |                    |          |        |
| Well/moderate           | 67                   | 64.016–69.984 | 0.871   | 69                 | 66.105–71.895 | 0.967   |
| Poor                    | 61                   | 40.716–81.284 |       | 67                 | 57.208–76.792 |        |
| Pathological stage      |                      |          |         |                    |          |        |
| Stage IA                | 67                   | 59.413–74.587 | 0.661   | 67                 | 59.409–74.591 | 0.759   |
| Stage IB                | 67                   | 63.543–70.457 |       | 69                 | 65.687–72.313 |        |
| Tumor location          |                      |          |         |                    |          |        |
| Left                    | 69                   | 66.376–71.624 | 0.094   | 70                 | 67.006–72.994 | 0.144   |
| Right                   | 63                   | 57.458–68.542 |       | 66                 | 61.524–70.476 | 0.133   |
| Surgical procedures     |                      |          |         |                    |          |        |
| Lobectomy               | 67                   | 63.255–70.745 | 0.138   | 67                 | 64.145–69.855 |        |
| Pneumonectomy           | 69                   | 54.781–83.219 |       | 69                 | 64.734–73.266 |        |

**Abbreviations:** CI, confidence interval; DFS, disease-free survival; ECOG, Eastern Cooperative Oncology Group; OS, overall survival.
Table 4 Univariate Kaplan–Meier analysis of DFS and OS according to inflammatory markers

| Inflammatory markers | DFS | OS |
|----------------------|-----|----|
|                      | Median (months) | 95% CI | P-value | Median (months) | 95% CI | P-value |
| Preoperative NLR     | ≤2.5 | 70  | 67.838–72.162 | 0.032 | 70  | 67.158–72.842 | 0.061 |
|                      | >2.5 | 49  | 25.75–72.25  | <0.001 | 60  | 50.489–69.511 | <0.001 |
| Postoperative NLR    | ≤3.9 | 70  | 67.374–72.626 | <0.001 | 70  | 68.299–73.701 |
|                      | >3.9 | 40  | 24.932–55.068 | 56  | 40.546–71.454 |
| ∆NLR                 | ≤1.5 | 72  | 68.801–75.199 | 0.004 | 72  | 69.27–76.73 |
|                      | >1.5 | 60  | 48.161–71.839 | 61  | 56.691–65.309 |
| Preoperative LMR     | ≤2.9 | 66  | 61.851–70.149 | 0.311 | 67  | 64.329–69.671 | 0.566 |
|                      | >2.9 | 71  | 64.07–77.93  | 0.262 | 70  | 61.684–78.316 |
| Postoperative LMR    | ≤2.6 | 65  | 58.903–71.097 | 0.103 | 69  | 60.919–71.081 | 0.116 |
|                      | >2.6 | 69  | 65.285–72.715 | 69  | 63.583–74.417 |
| ∆LMR                 | ≤−1.5| 65  | 60.217–69.783 | 0.025 | 66  | 60.539–71.461 | 0.011 |
|                      | >−1.5| 70  | 64.856–75.144 | 71  | 65.858–76.142 |
| Preoperative PLR     | ≤100 | 69  | 65.991–72.009 | 0.244 | 66  | 63.333–72.667 | 0.291 |
|                      | >100 | 66  | 57.728–74.272 | 66  | 61.156–70.844 |
| Postoperative PLR    | ≤144 | 69  | 65.469–72.531 | 0.291 | 69  | 66.646–71.354 | 0.268 |
|                      | >144 | 63  | 56.583–69.417 | 66  | 60.288–71.712 |
| ∆PLR                 | ≤24  | 69  | 65.513–72.487 | 0.849 | 69  | 66.724–71.276 |
|                      | >24  | 63  | 57.948–68.052 | 66  | 59.713–72.287 |

Abbreviations: CI, confidence interval; DFS, disease-free survival; LMR, lymphocyte-to-monocyte ratio; ∆LMR, change in LMR; NLR, neutrophil-to-lymphocyte ratio; ∆NLR, change in NLR; OS, overall survival; PLR, platelet-to-lymphocyte ratio; ∆PLR, change in PLR.

Multivariate analysis confirmed that postoperative NLR (hazard ratio [HR] =2.435, 95% CI: 1.526–4.322, P=0.001) and ∆NLR (HR =2.103, 95% CI: 1.332–3.883, P=0.012) were independent predictors of DFS and that postoperative NLR (HR =2.747, 95% CI: 1.668–4.408, P=0.001) and ∆NLR (HR =2.052, 95% CI: 1.225–3.468, P=0.018) were significant prognostic factors of OS (Table 5).

The Kaplan–Meier method was used to estimate DFS and OS curves, as stratified according to postoperative NLR and ∆NLR values (Figures 2 and 3). Differences in survival were evaluated using the log-rank test, which showed clear distinctions for all strata (DFS analyses: P<0.001 for postoperative NLR and P=0.004 for ∆NLR; OS analyses: P<0.001 for postoperative NLR and P=0.004 for ∆NLR).

Discussion

Several previous studies have suggested that preoperative inflammatory markers, such as NLR, LMR, and PLR, are useful...
prognostic markers for patients with NSCLC.\textsuperscript{8,19,20} However, these studies focused on the pretreatment values of inflammatory markers. Few studies have evaluated dynamic changes in markers, which might reflect the balance between the host inflammatory and immune responses. To our knowledge, this study is the first to demonstrate that postoperative NLR and ΔNLR are independent prognostic factors for patients who have undergone complete resection of stage I NSCLC.

Based on individual data from 123 patients who underwent pulmonary resection of stage I NSCLC, our
retrospective analysis demonstrated that postoperative NLR and ∆NLR – but not preoperative NLR – were significant prognostic factors. In recent years, some meta-analyses have supported the prognostic value of preoperative NLR in lung cancer.2,21 However, these studies enrolled patients with different stages of disease, especially patients with small-cell lung cancer, the biological behavior and prognosis of which differ from those of NSCLC. In comparison, few studies have focused on stage I NSCLC. Recently, a study by Miyazaki et al22 found that preoperative NLR was not correlated with 5-year survival in patients with stage I NSCLC. Accordingly, the understanding of preoperative NLR’s predictive role has changed for patients undergoing complete resection of stage I NSCLC. This study results revealed that preoperative NLR was not a predictor of survival in stage I NSCLC, in agreement with the report by Miyazaki et al. To the best of our knowledge, there has been no related study on postoperative NLR or ∆NLR in patients with stage I NSCLC. This study confirmed that postoperative NLR (HR = 2.435, P < 0.001) and ∆NLR (HR = 2.103, P = 0.012) were independent risk factors that predicted DFS. Furthermore, our results confirm that the significant predictors of OS include postoperative NLR (HR = 2.747, P < 0.001) and ∆NLR (HR = 2.052, P = 0.018). The results revealed that postoperative NLR and ∆NLR reflect the postoperative balance or change in the systemic inflammatory response from the preoperative period to the postoperative period, which may provide a more precise reflection of prognosis.

The relationship between NLR and prognosis currently appears to be complex, and the precise mechanisms involved are not fully understood. Increasing evidence supports the involvement of systemic inflammation in the extent of tumor progression and metastasis, with inflammatory processes contributing to cancer initiation, promotion, progression, and invasion. Neutrophils, the dominant subset of inflammatory cells, may stimulate tumor angiogenesis by producing vascular endothelial growth factor, matrix metalloproteinases, and elastases. On the other hand, lymphocytes in the tumor microenvironment play a substantial role in immune surveillance against tumor development. Hiraoka et al20 found that tumor infiltrating lymphocytes could inhibit tumor growth and were correlated with a favorable prognosis in lung cancer. Lymphocytes in the tumor microenvironment are mainly derived from the lymphocyte migration of peripheral blood, and the number of lymphocytes in the tumor microenvironment and in peripheral blood is considered as an important prognostic and predictive marker. Therefore, NLR could act as a marker reflecting the balance between host protumor inflammatory status and antitumor immune status. However, preoperative NLR only reflects the balance before surgery, while postoperative NLR represents the status after surgical removal of the tumor, which would be expected to provide a more precise indication of treatment response. Moreover, ∆NLR represents the dynamic variation between host inflammatory response and immune response from the preoperative period to the postoperative period, which can be used for early evaluations of treatment efficacy and predictions of survival.

The multivariate analysis in this study did not validate the associations between LMR, PLR, and long-term outcomes in patients undergoing complete resection of stage I NSCLC. LMR, one of the inflammatory biomarkers, was regarded as an independent prognostic factor for DFS and OS in previously untreated metastatic NSCLC patients receiving platinum-based doublet chemotherapy.33 However, Song et al34 found that the LMR values at initial diagnosis and disease progression were similar in patients with early-stage NSCLC (P = 0.287), which suggested that LMR would not be predictive of DFS. In a previous study of patients with all stages of NSCLC, PLR was observed to be an independent prognostic factor.35 However, for early-stage NSCLC, some studies confirmed that PLR was not associated with survival.5,6,10 Our results are in agreement with the latter studies, owing to the similar stages that were analyzed.

There has been no consistent opinion regarding the appropriate timing for postoperative measurement. Choi et al35 defined the postoperative NLR as the value obtained on postoperative day 1. However, NLR shows a peak at 24 hours after surgery, which is probably influenced by psychological and physiological factors. For example, surgery is a source of stress for patients and could change the systemic inflammatory state. Because the literature has shown that inflammation due to the surgical wound healing process ceases 1 month after the operation, postoperative measurements were chosen to perform at least 1 month after surgery to minimize the disturbances caused by the operation.

Our study has several limitations. 1) It was a retrospective study with a small sample size, which might have contributed to selection bias. 2) Because sufficient information was unavailable, the effects of different treatment regimens on survival was not analyzed after recurrence. 3) The generalizability of our findings might be limited because of the single-center design of our study. Therefore, a prospective, large sample, multicenter clinical study is needed to verify the reported results. Finally, this study did not involve laboratory data of intraindividual variations (different collection times)
and interindividual variations (different intervals, gender, or age), which might be the future research direction.

**Conclusion**

To the best of our knowledge, this is the first study to evaluate the prognostic significance of postoperative NLR and $\Delta$NLR in patients undergoing complete resection of stage I NSCLC. Postoperative NLR and $\Delta$NLR — but not preoperative NLR — were independent prognostic factors for DFS and OS in these patients with stage I NSCLC. The patients will be classified into two groups as low risk and high risk for individual assessment according to different values of the two parameters in further work. Further investigations are warranted to validate our findings.

**Disclosure**

The authors report no conflicts of interest in this work.

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