

## RE: Long-Term Outcomes of Sentinel Lymph Node Biopsy for Ductal Carcinoma *in Situ*

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We read with interest the paper by Hung et al. “Long-Term Outcomes of Sentinel Lymph Node Biopsy for Ductal Carcinoma in Situ”(1). The authors compared patients aged 67-94 years with ductal carcinoma in situ (DCIS) of the breast with a sentinel lymph node biopsy (SLNB) to those without a SLNB and did not find statistically significant differences for treated recurrence, ipsilateral invasive occurrence and breast cancer mortality. From this they concluded that the routine performance of SLNB is not warranted in older patients.

We do not think that this conclusion can be drawn based on the data they had available/selected for their analysis. As stated by Hung et al they used data from patients with a final diagnosis DCIS. This data does not reflect the complete diagnostic work-up. The use of SLNB is not intended as a staging procedure based on a final diagnosis of DCIS in the resection specimen. A SLNB is considered as a staging procedure, guidance of therapy and follow up pre-operatively in patients with biopsy-proven DCIS. Of these biopsy-proven patients, 20-25% will have invasive cancer as final diagnosis and this cancer needs to be staged (2). Staging of these invasive cancers by SLNB is not possible after a mastectomy and possibly less reliable after breast conserving surgery. In addition, it is more convenient to perform a one-stage procedure. Performing SLNB in all patients with biopsy-proven DCIS would result in unnecessary procedures in 70-75% of the patients that will have a final diagnosis of DCIS. Therefore, guidelines have been proposed to identify patients with an increased risk of a final diagnosis of invasive cancer (3,4). In the paper by Huang, patients with DCIS and SLNB were of younger age, higher grade DCIS, larger size and had lack of hormone receptor expression compared to patients with DCIS and no SLNB. All of these have been identified as risk factors for occult invasive cancers. The difference in distribution in the study of Huang of these factors

in patients with DCIS and SLNB versus without SLNB, indicates that the SLNB was done in selected patients, probably according to a guideline.

Guidelines on the use of SLNB in patients with biopsy-proven DCIS are divergent and so is the interpretation of these guidelines, since there also is considerable variation in the actual use of SLNB in these patients (5,6). To improve on this situation a critical evaluation of the guidelines is necessary, but also the development and validation of tools like (web-based) prediction models (nomograms) to support the decision making process (7). We therefore think that it is possible to reduce both the variation and the rate of unnecessary procedures. And thus we think that it is too early to abandon the use of SLNB in patients with biopsy-proven DCIS altogether.

## Note

Disclosures: the authors have no disclosures.

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