Techniques for sentinel node detection in breast cancer

Dear Editors,

The fundamental aim of the study by Siddique *et al*.[1] is sensible and noble. Nuclear medicine and surgical doctors, alike, can benefit immensely from understanding the relative efficacies of sentinel node mapping using radionuclide single-photon emission computed tomography lymphoscintigraphy (SPECT-CT LS) followed by gamma probe detection and the patent blue dye (PBD) technique. The assumption shall be made that they injected both the radiocolloid and the PBD in the same site. Of course, intuition would suggest that different outcomes are yielded if the injection site(s) were different, but this issue should not be encountered if using the same injection site(s).

Even so, there is a substantial discrepancy between the techniques even assuming the same injection site(s). This was also found with other injection techniques, not just subareolar as in this study: peritumoral[2] and intratumoral (intralesional).[3] So how do the authors recommend we approach this problem? It is a little unclear from the most recent guidelines[4,5] which we should use and when. If sentinel nodes are negative with radionuclide SPECT-CT LS, do we only then need to use PBD? Is that what Figure 1 should imply?

In our experience, we have found numerous cases where lymph nodes were radioactive but not blue and vice versa lymph nodes which were blue but not radioactive. We have identified malignancies in both groups. Would dual mapping – using both SPECT-CT LS and PBD methods – be the most ideal approach?

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Submitted: 30-Mar-2020, **Revised:** 28-May-2020, **Accepted:** 28-May-2020, **Published:** 14-Sep-2020

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Access this article online	
Website: www.wjnm.org	Quick Response Code
DOI: 10.4103/wjnm.WJNM_38_20	

How to cite this article: Lee JC, Tam DP. Techniques for sentinel node detection in breast cancer. World J Nucl Med 2020;19:445.