Point–Counterpoint Review

Cancer Research

Reply to Point

It Is Not Always Necessary to Do Axillary Dissection for T1 and T2 Breast Cancer

See Point by Morrow, p. 7151

Michael S. Sabel

Dr. M. Morrow is correct in stating that the axillary lymph node dissection (ALND) is no longer a standard management for patients with T1/T2, clinically node-negative patients found to have a positive sentinel node. However, we must be careful not to infer that to mean that ALND is no longer indicated in any of these patients or that if ALND is not indicated, then no axillary treatment is indicated. We must also be careful in how we define "clinically node negative" so as not to extrapolate trial results obtained from one group of select patients to all patients. Although it may be true that when the eligibility criteria of Z0011 are applied to a consecutive series of patients (as Memorial Sloan-Kettering Cancer Center investigators did), many (they reported 84%) would be "eligible," but that does not mean they are reflective. A 40-year-old patient undergoing breast-conserving therapy (BCT) and found to have two sentinel lymph node (SLN) completely replaced by tumor would technically be among the 84% of Z0011-eligible patients, but similar patients clearly were not accrued to this trial, and therefore it is hard to say that Z0011 justifies not considering ALND in this patient.

Interpreting these trials emphasizes the importance of multidisciplinary care in breast cancer. We must make these decisions in concert with our medical oncology and radiation oncology colleagues. Until we know more about the radiation received by patients on the Z0011 trial, including how many patients have adjusted tangents and how many may have received axillary radiotherapy, we must be careful in defining who can avoid additional axillary surgery because they will receive axillary radiation, who can avoid any axillary therapy, and those patients who should still be considered for ALND. Although my personal belief is that tumor burden within the SLN (something not recorded in Z0011) is likely the strongest determinant of this, further research into its correlation with burden of disease left in the non-SLNs (as opposed to simply the presence of disease, as most nomograms predict) is necessary.

To some degree, the Z0011 trial feels like déjà vu all over again. It was not long ago that based on the NSABP B06 trial (and others), we offered lumpectomy alone as a viable treatment option, based on prospective randomized trial data showing no impact of local recurrence on overall survival. Countless textbooks, articles, and editorials reiterated this argument, and many women had lumpectomy alone. Years later, the Early Breast Cancer Trialists' Collaborative Group (EBCTCG) showed not only the impact local control had on survival, but also the importance of both adequate numbers of patients and adequate follow-up, both of which have been questioned with Z0011. As much as we all want to minimize the morbidity associated with breast surgery, we must be careful to avoid a similar mistake. Although many patients for whom we previously recommended ALND can now safely avoid it, there are still some "Z0011-eligible" patients for whom ALND should still be considered, and those decisions must be made in a multidisciplinary fashion.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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