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LETTER – BREAST ONCOLOGY

Letter to the Editor of Annals of Surgical Oncology concerning "Is Choosing Wisely Wise for Lobular Carcinoma in Patients over 70 Years of Age? A National Cancer Database Analysis of Sentinel Node Practice Patterns"

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Dear Editor:

Kudos to Dr. Goldhaber and colleagues for evaluating the safety of omitting sentinel lymph node biopsy in women over the age of 70 years with T1 invasive lobular carcinoma (ILC).[1] As the authors point out, ILC remains an understudied yet relatively common breast cancer subtype, heightening the importance of ILC-specific analyses to optimize its treatment.

The historic importance of axillary staging for guiding breast cancer treatment has been largely supplanted by our increased understanding of tumor biology. The availability of gene expression assays to guide systemic therapy decisions, concerns about morbidity from axillary staging procedures, and lack of impact on survival outcomes has led many to question the utility of sentinel lymph node biopsy in select populations.[2] However, the recent approval of certain systemic treatments depends on accurate staging data, potentially bringing the role of axillary surgery to the forefront again.

In the phase III MonarchE study, the addition of adjuvant abemaciclib to endocrine therapy led to significantly improved disease-free and distant-relapse-free survival in patients with hormone receptor positive, HER2 negative, node-positive breast cancer.[3] Patients were eligible to enroll if they had ≥ 4 positive axillary lymph nodes or 1–3 positive nodes and tumor size ≥ 5 cm, histologic grade 3, and/or ≥ Ki-67 20% (notably, 27% of the study population had T1 tumors). Subgroup analyses showed that treatment benefit was maintained even among patients aged 65 years or older, who represented approximately 15% of the study population.

As pointed out in this current analysis, several series have shown that patients with ILC present at more advanced stages than those with invasive ductal carcinoma (IDC), making patients with ILC potentially more likely to meet the inclusion criteria for MonarchE.[4] Indeed, a Swedish national registry study in which average age at diagnosis of ILC was 65 years showed that patients with ILC were significantly more likely to have four or more positive nodes than those with tumors of no special type.[5]

Given the higher rates of discordance between clinical and pathologic staging in patients with ILC, we wonder about the nodal positivity rate for clinical T1 cases rather than pathologic T1 cases. Furthermore, given the implications of node positivity for adjuvant therapy decisions, the difference in number of positive nodes among the node-positive patients with lobular and non-lobular histology would also be of interest.

While the authors' data are reassuring that a select subset of patients with ILC has a low likelihood of having positive nodes, our ability to correctly identify that subset preoperatively may be impaired by low imaging sensitivity. This could result in a missed opportunity for additional adjuvant therapy in some patients that could impact adjuvant treatments and recurrence outcomes.

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