LETTER TO THE EDITOR

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TO THE EDITORS:

We read the original article on sentinel lymph node (SLN) biopsy by Hirche et al.¹ with great interest, particularly as inguinal sentinel node detection with indocyanine green retention fluorescence appears to hold promise, despite its low detection rate as compared with the radio-nuclide technique.^{2,3} Furthermore, the detection rate with the combined technique (radiocolloid with blue dye) seems low in their study, given that rates of 100% are generally achieved, as Hirche et al. admit. In the Patients and Methods section, they state that their protocol included inguinal radiotherapy (RT) for all 12 patients studied: 30.6–36 Gy in T1 patients with SLN negative for metastases (MTS) and 54–59.4 Gy in positive SLN; while they treated other patients with 36 Gy (T2)–45 Gy (T3–4) for inguinal SLN negative for MTS, or 54–59.4 Gy for positive SLN. In the discussion, however, they state that “In this study, none of the 10 patients with negative SLN who did not undergo inguinal irradiation developed metachronous MTS after a median follow up of 44 months”. This seems to contradict what was mentioned in Patients and Methods. In addition, it is unclear why inguinal RT and why different RT doses were delivered in patients negative for inguinal MTS. As reported previously,^{2,3} the concept of SLN in anal cancer was developed to obviate the need for inguinal RT in patients negative for inguinal MTS and to reduce cumulative morbidity, which occurs in 33% of patients. Although it might be therapeutic in many patients, delivering 30.6–45 Gy of RT in patients negative for MTS is associated with a rate of morbidity that could surely be avoided. This makes it difficult to compare this study with others where prophylactic inguinal RT was not performed. The reported absence¹ of inguinal metachronous MTS may be related to this treatment protocol. The SLN technique is expensive¹ and has a low, but not negligible rate of minor

morbidity, and should therefore be avoided if prophylactic inguinal RT is performed in all patients. Otherwise, we might wish to agree with Gretschel⁴ who suggested that SLN biopsy in anal cancer can be used to appropriately select patients for inguinal irradiation, especially in T1 and T2 tumors, and that SLN biopsy is not currently recommendable for larger (T3/T4) tumors or in patients with prior surgical manipulation of the anal or inguinal region in which an inguinal RT must be performed, considering the high incidence of MTS.

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