ASO Author Reflections: Sentinel Lymph Node Biopsy for Ductal Carcinoma In Situ with Suspicion for Microinvasion on Core Needle Biopsy

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PAST

Ductal carcinoma in situ (DCIS) represents 24% of all new breast cancer diagnoses in the US,¹ and DCIS with suspected or definite microinvasion (DCISM) comprises about 10% of these cases.² The DCISM literature to date suggests a 2–20% rate of sentinel lymph node (SLN) metastasis, but is based on the *final surgical pathology*, not the core biopsy that is the basis for the surgeon's decision to perform SLN biopsy (SLNB).³ The aim of our study⁴ was to define the extent of T/N upstaging and the role of SLNB following a core needle biopsy diagnosis of *suspected versus definite* DCISM, drawing on a well-annotated cohort of recent patients.

PRESENT

For patients with *suspected versus definite* DCISM on core biopsy, 28% and 37%, respectively, were upstaged by surgical excision to invasive cancer, and 1% and 6%, respectively, were upstaged by SLNB to pN1 nodal disease.⁴ The median size of invasive cancer was 0.2 cm. On multivariate analysis, the odds of nodal metastasis were significantly higher with definite DCISM (odds ratio 7.85, $p = 0.048$), but we did not find any other patient, imaging,

or core biopsy characteristics that could reliably select patients for SLNB. Our results are concordant with the only other study that, to our knowledge, addresses this topic.⁵

FUTURE

We suggest that SLNB at the time of initial surgery makes sense for patients with a core biopsy diagnosis of definite DCISM, but not for suspected DCISM, where the rate of clinically significant nodal metastasis (1%) is comparable with that of pure DCIS. Since these results represent a tertiary center with dedicated breast imagers, pathologists, and surgeons, we welcome confirmatory studies on a broader basis.

DISCLOSURES Meghan R. Flanagan and Hiram S. Cody III have no conflicts of interest to disclose.

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