LETTER TO EDITOR

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Axillary De-Escalation: Precision Matters

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Dear Editor,

We read with interest the review by Mukherjee et al. (1) on omission of sentinel lymph node biopsy (SNB) in early-stage breast cancer. The topic is important and evolving. However, several key elements essential for safe clinical implementation are insufficiently defined or omitted in their review. This becomes apparent when the review is considered alongside contemporary guideline recommendations (2).

First, current recommendations do not support a broad or biologically vague omission strategy. They define a highly selected patient population in whom SNB may be safely omitted: postmenopausal women aged ≥50 years, with unifocal invasive ductal carcinoma ≤2 cm, Nottingham grade 1–2, hormone receptor-positive/human epidermal growth factor receptor 2-negative disease, a negative preoperative axillary ultrasound (or a single suspicious node with benign concordant biopsy), planned adjuvant endocrine therapy, and upfront breast-conserving surgery followed by whole-breast radiotherapy (2). In contrast, Mukherjee et al. (1) refer to “low-risk” or “favourable” disease without consistently presenting these criteria as mandatory conditions, thereby risking overextension of the concept.

Second, omission of SNB is explicitly conditioned on the assumption that nodal information would not change adjuvant systemic or radiotherapy decisions. Preoperative multidisciplinary discussion is therefore essential. This safeguard is not highlighted in the review, despite its central role in preventing undertreatment.

Third, the contemporary American Society of Clinical Oncology (ASCO) guideline introduces an important age-specific nuance (2). In patients ≥65 years who otherwise meet omission criteria, radiotherapy after breast-conserving surgery is not mandatory. This distinction, derived from CALGB 9343 and PRIME II, has direct implications for shared decision-making (3, 4). Mukherjee et al. (1) do not address this age-specific consideration and implicitly present radiotherapy as standard, thereby overlooking an established opportunity for further treatment de-escalation in selected older patients.

Fourth, ASCO defines surgery-specific axillary pathways after mastectomy (2). Patients with one to two positive sentinel nodes may omit completion axillary dissection only if postmastectomy regional nodal irradiation is planned. In the absence of such radiotherapy, axillary dissection remains recommended. These decision pathways are only superficially discussed in the review, despite their clear clinical relevance.

Finally, ASCO is explicit about what should not be done: routine SNB for ductal carcinoma in situ treated with breast-conserving surgery is discouraged (2). SNB should not be performed solely to evaluate internal mammary nodes. Nor should SNB replace axillary dissection in inflammatory breast cancer or in the presence of biopsy-proven palpable axillary disease (2). These explicit “red lines” are not systematically highlighted.

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In summary, the review by Mukherjee et al. (1) is timely and informative. However closer alignment with the prescriptive structure of the current recommendations would improve its clinical precision. In axillary de-escalation, nuance is not optional. Precision is the safety net. Clear eligibility criteria, explicit contraindications, and treatment-altering decision points are essential to ensure that "less" surgery truly remains "no less" care.

Footnotes

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