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Comment on “Sentinel Lymph Node Biopsy for Breast Cancer in North Africa: A Retrospective Analysis of Feasibility, Safety, and Morbidity Reduction in a Real-World Setting”

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Dear Editor,

We read with great interest the article by Belkhodja et al. (1) evaluating the implementation of sentinel lymph node biopsy (SLNB) for early-stage breast cancer at the Maternity Center of Bizerte, Tunisia. This retrospective study of 64 patients compared SLNB with axillary lymph node dissection (ALND) and reported an 89% SLN detection rate using a dual-tracer technique (technetium-99m and methylene blue). The study demonstrates reduced postoperative morbidity in patients undergoing SLNB, including lower incidence of lymphedema, less hemoglobin loss, shorter hospital stay, less pain, and fewer limitations in arm mobility.

The study provides valuable insights, particularly through its detailed description of the SLNB technique and intraoperative procedures; comprehensive data collection from patient records, pathology reports, surgical logs, and follow-up; and its contribution of evidence from a previously underrepresented population.

However, several limitations should be noted. Providing additional details on patient characteristics, including age distribution and menopausal status, would not only help

contextualize the observed outcomes but also allow a more precise comparison with international guidelines and facilitate interpretation of SLNB applicability across different patient subgroups (2).

Additionally, limited details regarding tumor grade and hormone receptor/human epidermal growth factor receptor 2 status restrict precise assessment of patient risk and consideration of omitting ALND or SLNB. Existing evidence highlights the importance of these parameters for informed patient selection and for guiding adjuvant therapy (3).

Furthermore, the study includes N1 patients; what criteria were used to decide whether to perform ALND after a positive SLNB? How do these criteria align with current guidelines that recommend omission in patients with one or two positive SLNs under defined conditions (4)? Additionally, could a longer follow-up period provide a more complete assessment of late recurrences, particularly among luminal subtypes? In patients receiving neoadjuvant chemotherapy (NAC), the absence of reported clipping of the target node may underestimate residual nodal disease, raising the possibility of false-negative SLNB results (5).

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This study demonstrates the feasibility of SLNB and its benefits in reducing morbidity in a Tunisian setting, and highlights key aspects of its implementation.

Recent consensus suggests that SLNB may be safely omitted in select postmenopausal patients with favorable tumor characteristics, serving primarily as a staging tool rather than determining systemic therapy (2). Notably, the reported 11% SLNB failure rate appears to largely reflect cases with extensively involved nodes rather than procedural limitations.

Although the study is limited by its retrospective, single-center design and relatively small cohort, it nonetheless provides valuable real-world data. Careful patient selection, incorporation of targeted node clipping for NAC, and extended follow-up could further strengthen the safe application of axillary de-escalation strategies in similar settings, ultimately supporting evidence-based, individualized surgical management.

Footnotes

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