Reviewer's report

Title: Sentinel node biopsy for breast cancer: is it already a standard of care? A survey of current practice in an Italian region

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Reviewer: H Cody

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General
Here the authors review the patterns of use of sentinel lymph node (SLN) biopsy for axillary node staging in breast cancer, among surgeons in the Veneto region of Italy. They achieve a response rate of 82% using a questionnaire format, and they cover practice demographics, case selection, and technical issues. Since the BMC is electronic and does not have space constraints, I suggest that the authors' full questionnaire also be published as an appendix.

Discretionary Revisions (which the author can choose to ignore)

None.

Minor Compulsory Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

None.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Page 3. SLN biopsy is a diagnostic test and as such does not require a randomized trial for validation. It has been validated worldwide by numerous observational studies and in one randomized trial to date (Veronesi, NEJM 2003) which the authors should cite. Two short-term (Veronesi, Giuliano) and one longer-term (Veronesi, 2003) follow-up study show no local recurrences after a negative SLN biopsy.

Page 6. While 100% of the academic surgeons did SLN biopsy, it's interesting that 20% of high volume centers did not. The authors might want to comment on this in the discussion. Also, while 70% of surgeons did SLN biopsy, 93% felt that it was ready for use in clinical practice (suggesting that logistical issues, and not surgeon reluctance, are the main barrier to the universal adoption of SLN biopsy). The authors might want to comment further on this in the discussion.

Page 7-9. It seems that none of the surgeons do SLN biopsy for tumors larger than 3 cm. While one might expect more false-negative results for T>3 cm, three separate studies (Olson, Bedrosian, Giuliano) all show that SLN biopsy is just as accurate for larger tumors as it is for small ones.

Page 7. It's surprising that only one third of the surgeons examine the SLN intraoperatively. This ensures a reoperative axillary dissection for the 30-40% of patients who prove to be SLN-positive. This represents a substantial added expense in a setting where health care resources are limited. The authors might want to address this in the discussion.

Page 9. The discussion could be condensed. I suggest that the authors refer to the results of the American and Canadian patterns-of-use surveys, and discuss the similarities and differences from their own findings.

Page 10. Regarding the learning curve, the best study is that of McMasters, which suggests that 20 cases with backup ALND are enough. False negative results are not more frequent with larger
tumors (see above).

page 11. The authors should discuss further the low rate of intraoperative SLN examination.

page 12. This study suggests that the Veneto surgeons would ALL do SLN biopsy if they had the equipment. One cannot argue with the authors' advocacy for instructional courses and a program of quality control, but I would give equal emphasis to the underlying logistical issue, and recommend that the health authorities immediately obtain a gamma probe for every hospital that needs one.

What next?: Accept after minor compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: No

Declaration of competing interests:

None.