Ganglion sentinelle après chimiothérapie néo-adjuvante chez les patientes présentant un cancer du sein avec atteinte ganglionnaire initiale : rationnel scientifique et prise en charge aux Hôpitaux Universitaires de Genève

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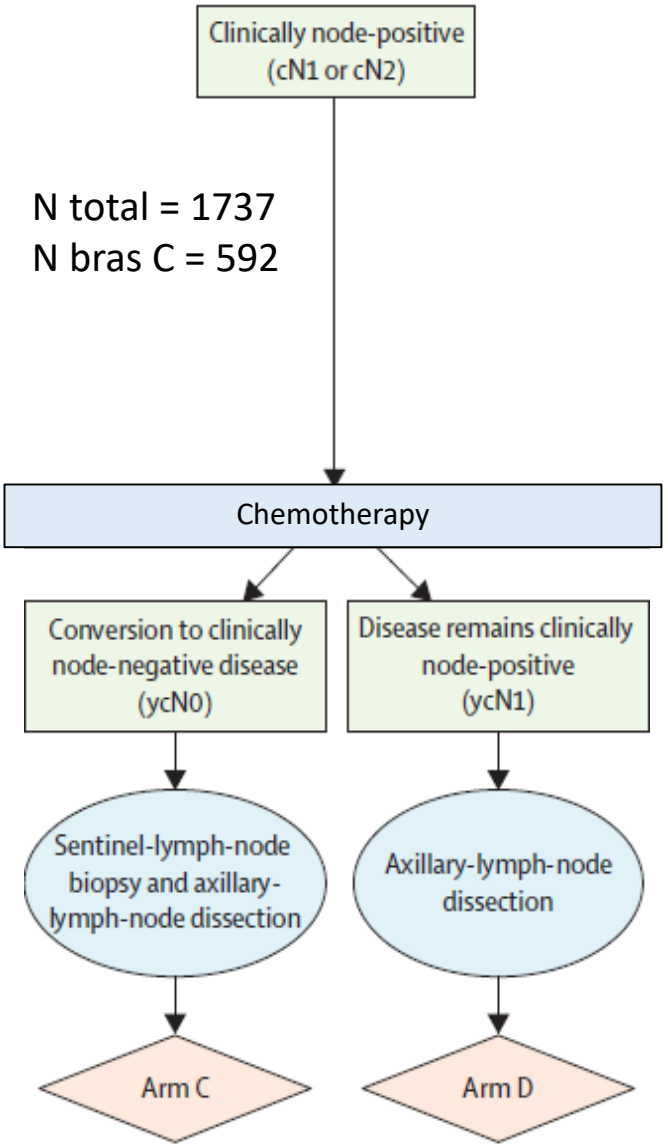
Hôpitaux Universitaires Genève

Aucun conflit d’intérêt

Abréviations:
GS: ganglion sentinelle
GG: ganglion
CA: curage axillaire
CNA: chimiothérapie néoadjuvante
FN: faux négatif

La chirurgie axillaire après CNA chez les patientes initialement N+: La technique du ganglion sentinelle est-elle possible?
INTRODUCTION



N total = 1737
N bras C = 592

Sentinel-lymph-node biopsy in patients with breast cancer before and after neoadjuvant chemotherapy (SENTINA): a prospective, multicentre cohort study

Thorsten Kuehn, Ingo Bauerfeind, Tanja Fehm, Barbara Fleige, Maik Hausschild, Gisela Helms, Annette Lebeau, Cornelia Liedtke, Gunter von Minckwitz, Valentina Nekljudova, Sabine Schmatloch, Peter Schrenk, Annette Staebler, Michael Untch

	Arm B (n=64)	Arm C (n=226)
Overall false-negative rate (n/N; 95% CI)	51·6% (33/64; 38·7–64·2)	14·2% (32/226; 9·9–19·4)
False-negative rate, according to number of sentinel nodes removed		
1	66·7% (16/24)	24·3% (17/70)
2	53·8% (7/13)	18·5% (10/54)
3	50·0% (5/10)	7·3% (3/41)
4	50·0% (3/6)	0·0% (0/28)
5	18·2% (2/11)	6·1% (2/33)
False-negative rate, according to detection technique		
Radiocolloid alone	46·2% (18/39)	16·0% (23/144)
Radiocolloid and blue dye	60·9% (14/25)	8·6% (6/70)

Data are rate (number of patients), unless otherwise stated.

Table 4: **False-negative rate of sentinel-lymph-node resection in patients with positive nodes, according to selected factors**

Taux de détection 80 %
Taux de FN <10% si plus de 3 GS
Taux de FN <10% si détection double méthode

Thorsten *et al*. Lancet 2013

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INTRODUCTION

Original Investigation

Sentinel Lymph Node Surgery After Neoadjuvant Chemotherapy in Patients With Node-Positive Breast Cancer

The ACOSOG Z1071 (Alliance) Clinical Trial

Judy C. Boughey, MD; Vera J. Suman, PhD; Elizabeth A. Mittendorf, MD, PhD; Gretchen M. Ahrendt, MD; Lee G. Wilke, MD; Bret Taback, MD; A. Marilyn Leitch, MD; Henry M. Kuerer, MD, PhD; Monet Bowling, MD; Teresa S. Flippo-Morton, MD; David R. Byrd, MD; David W. Ollila, MD; Thomas B. Julian, MD; Sarah A. McLaughlin, MD; Linda McCall, MS; W. Fraser Symmans, MD; Huong T. Le-Petross, MD; Bruce G. Haffty, MD; Thomas A. Buchholz, MD; Heidi Nelson, MD; Kelly K. Hunt, MD; for the Alliance for Clinical Trials in Oncology

Etude prospective multicentrique
N = 756 T0-T4
cN1 (N=663), cN2 (N=38) traitées par CNA puis GS et CA

	False-Negative SLN Findings, No. (Total)	FNR (95% CI), %	Fisher Exact Test, *P* Value
Mapping agents used			
Single	12 (59)	20.3 (11.0-32.8)	.05
Dual	27 (251)	10.8 (7.2-15.3)	
No. of SLNs examined			
2	19 (90)	21.1 (13.2-31.0)	.007
≥3	20 (220)	9.1 (5.6-13.7)	

Improved Axillary Evaluation Following Neoadjuvant Therapy for Patients With Node-Positive Breast Cancer Using Selective Evaluation of Clipped Nodes: Implementation of Targeted Axillary Dissection

Abigail S. Caudle, Wei T. Yang, Savitri Krishnamurthy, Elizabeth A. Mittendorf, Dalliah M. Black, Michael Z. Gilcrease, Isabelle Bedrosian, Brian P. Hobbs, Sarah M. DeSnyder, Rosa F. Hwang, Beatriz E. Adrada, Simona F. Shaitelman, Mariana Chavez-MacGregor, Benjamin D. Smith, Rosalind P. Candelaria, Gildy V. Babiera, Basak E. Dogan, Lumarie Santiago, Kelly K. Hunt, and Henry M. Kuerer

N = 208

Taux de faux négatif

GS seul=
10,1% (95% IC 4.2 à 19,8)

GS + exérèse du ganglion clipé
=1,4% (95% IC, 0.03 à 7.3)
P=0.03

Caudle *et al*. JCO 2016
Judy *et al.* JAMA 2013

La chirurgie axillaire après CNA chez les patientes initialement N+: La technique du ganglion sentinelle est-elle possible? RECOMMENDATIONS INTERNATIONALES

De-escalating and escalating treatments for early-stage breast cancer: the St. Gallen International Expert Consensus Conference on the Primary Therapy of Early Breast Cancer 2017

Axillary surgery following neoadjuvant therapy

The Panel deliberated on appropriate axillary surgery following neoadjuvant chemotherapy. In a woman who presented with a clinically negative axilla and who received neoadjuvant treatment, the Panel strongly believed sentinel node biopsy to be appropriate and favored the biopsy be carried out after neoadjuvant treatment.

There was more controversy regarding sentinel node surgery for women who presented with a clinically positive axilla, and had a clinical response with down staging to a clinically negative axilla. The Panel believed sentinel node biopsy, as opposed to axillary dissection, to be adequate if at least three or more negative sentinel nodes were detected and examined [11–14]. Because of concerns for false-negative results with limited sampling, sentinel node surgery was generally considered not adequate if only one or two negative sentinel nodes were identified. The Panel recommended that patients with a clinically positive axilla or with macrometastases identified in sentinel nodes after neoadjuvant therapy undergo completion axillary dissection [15]. The Panel was split on whether residual micro-metastatic lymph node involvement warranted completion dissection after neoadjuvant therapy.

Management of the Axilla in Early–Stage Breast Cancer: Ontario Health (Cancer Care Ontario) and ASCO Guideline

Muriel Brackstone [1], Fulvia G Baldassarre [2], Francisco E Perera [1], Tulin Cil [3], Mariana Chavez Mac Gregor [4], Ian S Dayes [5], Jay Engel [6], Janet K Horton [7], Tari A King [8], Anat Kornecki [9], Ralph George [10], Sandip K SenGupta [11], Patricia A Spears [12], Andrea F Eisen [13]

Patientes N+ , ycN0 après CNA
Si mastectomie ou traitement conservateur
-Détection double méthode
-Exérèse du ganglion clipé
-Au moins 3 GS

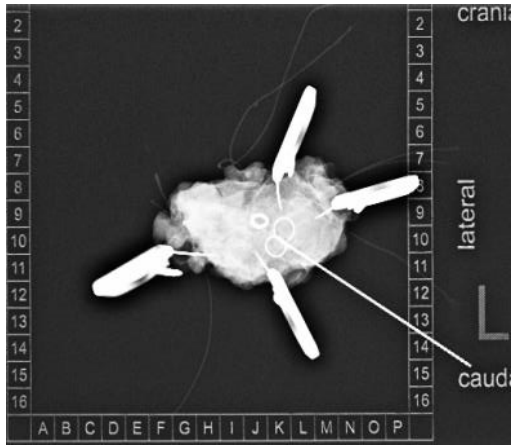
Muriel Brackstone *et al.* JCO 2021
G.Curigliano *et al.* Annals of Oncology 2017

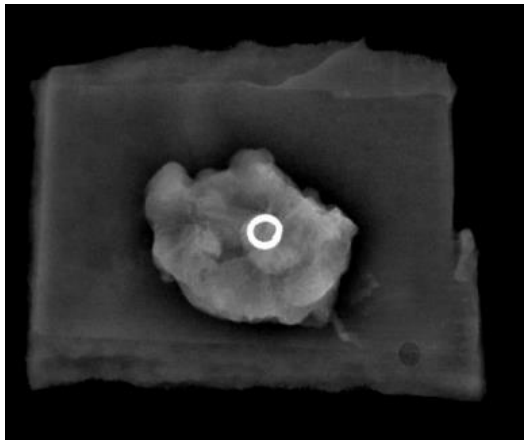
Quelle est notre expérience aux HUG pour la prise en charge des patientes initialement cN1 ayant une réponse radiologique complète après CNA?

Méthode

14 patientes cN1 initiale ayant une réponse radiologique complète après CNA

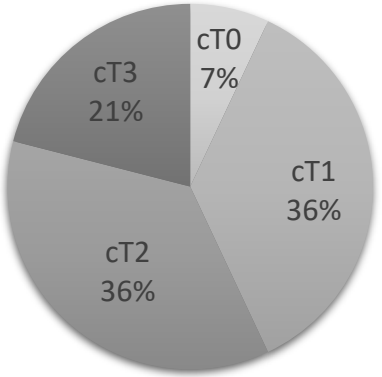
-clipage, repérage préopératoire et exérèse du ganglion biopsié
-repérage par double méthode isotopique et colorimétrique
-prélèvement d'au moins 3 ganglions sentinelles
-examen extemporané des ganglions



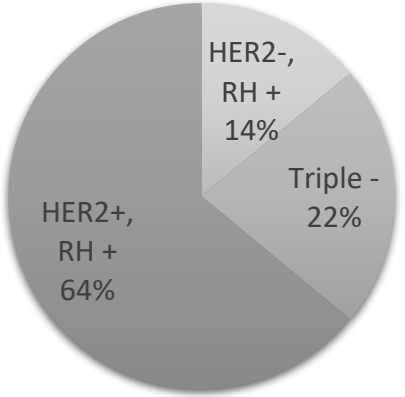


Résultats

Stade TNM



Type histologique



4 gg retirés en moyenne

100% des gg clipés retrouvés

92,8 % des gg clipés sentinelles

1 gg positif à l'extemporané

CONCLUSION

Technique réalisable

Critères rigoureux pour diminution des FN:

-Détection double méthode

-Exérèse du ganglion clipé

-Au moins 3 GS

Attendons les résultats des études prospectives en cours afin de pouvoir implémenter cette technique


Merci de votre attention