

Comment on Kraft O. et al. Detection of sentinel lymph nodes in cervical cancer. Comparison of two protocols — a reply

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We have read the comments by Wydra and Romanowicz with great interest. We agree with them, that the difference in detection rates between the protocols (one day and two day protocols) found in our study [1] could be related to the timing.

We start our procedures with Nanocoll tracer, when we have performed two day protocols, and then we continue with Sentscint. We have also changed our protocol on one day one. That is why the choice of radiocolloids for patients with various FIGO stages was accidental and it was a consequence of these facts. Specifically, in 1 patient with FIGO stage IA1 we used Nanocoll (two-day protocol), in 2 patients with IA2 Nanocoll (two day protocol) and in 30 patients with IB1: in 8 patients Nanocoll (1 one-day protocol, 7 two-day protocols), in 1 Nanocis (two-day protocol), in 21 pts Sentscint (3 two-day protocols and 18 one-day protocols), in 2 pts with IB2 Sentscint (1 one-day and 1 two-day protocols), in one patient with IIIA Sentscint — one-day protocol, in 18 patients with IIIB: 11 patients Sentscint (2 two-day and 9 one-day protocols) and 7 patients Nanocoll (two-day protocols).

We agree that FIGO stage III would not normally be selected for sentinel lymph node detection and biopsy because of its advanced stage, but our indication for surgery and SLN biopsy is

done on the basis of clinical staging. However, in our study, final surgical and histopathological staging have differed from clinical staging by up to 40%. All examined patients have been incorporated in the study including those with advanced stage cancer.

In our other study we had 63 patients with early stage cervical cancer (stage FIGO IA2–IIA). By combining patent blue dye and radiocolloid, SLN was detected in 59 patients (93.6%), from which 49 patients (78%) were bilateral and 10 patients (16%) were unilateral. In 4 patients (6%) SLN detection was not successful.

Detection rate of SLN was dependent on tumour size. With larger tumour size, detection success was lower. In stage FIGO IB2 (tumour size above 4 centimetres) detection was only 50%. This was caused by more difficult radiocolloid injection into the cervix, by present necrosis and by the fact that these patients had had neoadjuvant chemotherapy before surgery.

Detection success of SLN is also dependent on the FIGO stage — the higher stages had lower detection rates (however, stage IIA with vaginal spread did not have worse detection success of SLN than stage IB2). Patients' age, histopathological tumour differentiation or previous conisation did not have an influence on the detection rate. The relation between histopathological tumour type and SLN detection success has not been possible to assess as a result of the small number of our patients.

References

1. Kraft O, Sevcik L, Klat J et al. Detection of sentinel lymph nodes in cervical cancer. Comparison of two protocols. Nucl Med Rev Cent East Eur 2006; 9: 65–68.

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