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J Clin Oncol. 2000, 18: 2553-2559.CAS PubMed Google Scholar Page 2 Policies Accessibility Press center Support and Contact Leave feedback Careers Follow BMC BMC Twitter page BMC Facebook page BMC Weibo page Staging a cancer involves evaluating the primary tumour (the T stage), spread to the lymph nodes (the N stage) and spread of metastases elsewhere (the M stage). Sentinel node biopsy, often abbreviated to SNB, is a surgical procedure used to determine the N stage soon after the cancer has been diagnosed. It is often used in patients with cutaneous melanoma.How does cancer spread?Cancer can spread through the body (metastasise) by three common routes:Direct invasion of surrounding tissue Via blood vessels Via lymph vessels (the lymphatic system) What is the lymphatic system?Lymph vessels transport milky fluid called lymph, which drains through lymph nodes. Lymph nodes entrap foreign or potentially harmful substances, such as bacteria and cancer cells. Groups of lymph nodes are easily felt around the neck when they become enlarged and sore during an upper respiratory tract infection or sore throat. Other main groups of nodes are located in the groin (draining the leg), armpits (draining the arm), deep in the chest, and in the abdomen.How can one tell if cancer has spread to the lymph nodes?If the cancer has spread to the nearby lymph nodes, they may be obviously enlarged and are firm or hard on palpation. This may be detected by the patient or by a doctor on routine follow-up examination. Other reasons for enlarged lymph nodes include infection, inflammatory skin disease or a haematological cause (eg lymphoma).Tests to find out if the nodes contain cancer cells include:Ultrasound scan (sonography) Computerised tomography (CT) scan or magnetic resonance imaging (MRI) Fine needle aspiration (FNA) (sucking up cells through a hollow needle inserted through the skin over the enlarged node) Surgical biopsy A pathologist examines FNA or biopsy tissue under a microscope and reports the findings to the surgeon. If the biopsy is positive for cancer, the surgeon may recommend that all the lymph nodes in the area be removed (completion lymphadenectomy). Examining lymph nodes around the site of the primary cancer can help determine the extent of cancer spread via the lymph vessels. Spread to the nearby lymph nodes may reduce the chance of survival (prognosis), and the cancer may require different treatment.LymphadenectomyLymphadenectomy or lymph node dissection refers to the surgical removal of cancerous lymph nodes, usually after confirmation that they contain cancer cells.Patients may be advised to have the draining lymph nodes removed 'just in case' they have collected cancer cells; this prophylactic procedure is known as elective lymph node dissection. In melanoma, there is no evidence for a survival benefit from elective lymph node dissection, ie, melanoma patients who have this procedure do not live any longer than those who do not.Lymphadenectomy may lead to serious side effects including: What is sentinel node biopsy?Sentinel node biopsy involves biopsy of a lymph node soon after the primary cancer is diagnosed. A sentinel lymph node is the very first lymph node to which lymph from the cancer site is likely to drain, but is not yet enlarged. A negative sentinel lymph node biopsy indicates a lower risk that the cancer has spread than if the biopsy shows cancer cells.Sentinel node biopsy is performed by cancer surgeons as a staging procedure in some patients with skin cancer. Diagnoses include:When is sentinel node biopsy used in a patient with melanoma?Melanoma specialists vary in their opinion regarding the value of the procedure. The use of sentinel node biopsy in melanoma patients has created much controversy in the medical literature. The clinical practice guidelines for the diagnosis and management of melanoma (Australia) updated in 2017, state:The status of the sentinel lymph node is the most significant predictor of melanoma-specific survival for patients with melanoma >1 mm Breslow thickness. Overall, for patients with melanoma > 1 mm thick, sentinel lymph node biopsy followed by immediate completion lymph node dissection for a positive node does not prolong melanoma specific survival or overall survival compared with not performing sentinel node biopsy (nodal observation) and delayed lymph node dissection for clinically detected nodes. For patients with intermediate thickness melanoma (1.2-3.5 mm thick) who harbour metastatic disease within the sentinel node, early intervention with sentinel lymph node biopsy may be associated with an increased melanoma specific survival compared with nodal observation. Complication rates for sentinel lymph node biopsy are low. The procedure should be performed in a centre with appropriate expertise as complication rates are inversely related to procedure volume - this particularly applies to primaries arising in the head and neck. Sentinel node biopsy provides:More accurate staging, determining prognosis The opportunity to perform early lymphadenectomy, if the biopsy is positive, which provides better disease control and fewer side effects than waiting until the nodes are enlarged Identification of patients that may benefit from specific therapy and participation in clinical trials Survival advantage in some patients with positive biopsy, due to early lymph node clearance. Arguments against sentinel node biopsy in melanoma include:Breslow thickness, mitotic rate and presence or absence of ulceration, provide sufficient prognostic information Sentinel node biopsy can cause complications (see below) Completion lymphadenectomy for positive biopsy may be unnecessary Completion lymphadenectomy results in adverse events in one-third of patients, including clinically significant lymphoedema following axillary or groin dissection in up to 25% of patients There is lack of data to support using the results of sentinel node biopsy as inclusion criteria for immunotherapy or targeted therapy trials or treatment Lack of evidence for survival advantage in patients undergoing sentinel node biopsy. The largest trial of sentinel node biopsy (MSLT-1 [1,2]) reported in 2014 that the procedure provides useful prognostic information in patients with intermediate-thickness or thick primary melanomas. The authors considered the data also showed a survival benefit for node-positive patients. The scientific conduct and reporting of this trial have been criticised, with some authors providing an argument against recommending the procedures [3,4,5,6]. A further study (MSLT-II [9]) published in 2017, found that immediate completion lymph-node dissection increased the rate of regional disease control and provided prognostic information but did not increase melanoma-specific survival among patients with melanoma and sentinel-node metastases.Note:Prognostic information can be obtained from the initial excision specimen. Patients with a negative sentinel node biopsy may still develop metastases from melanoma. Patients with a positive sentinel node biopsy may not go on to develop metastases elsewhere. Sentinel lymph node biopsy procedureLymphatic draining patterns vary and it is not always obvious where to explore for metastatic cancer cells. To find the sentinel lymph node a doctor or technician injects a small amount of either blue dye or radioactive tracer near the original cancer. The success rate is best if both are used.The radioactive tracer is an isotope of technetium (Tc). It results in less exposure to radiation than that received during a standard X-ray. It disperses over a short time. Often, a scan of all lymph node basins is performed soon after the tracer is injected, using a special camera (lymphoscintigraphy).Twenty minutes or up to a few hours after the injection, a radioactive scanner (Geiger counter) is held over the skin and makes a noise when it encounters the radioactive tracer. Approaching from the direction of the original cancer, the first 'hot spot' encountered is the sentinel lymph node. A small cut is made into the skin overlying the area and the sentinel lymph node is removed. It is easier to find the node if dye has been injected, as it is stained blue. Sometimes more than one sentinel lymph node is detected in one or more body sites.Sometimes the sentinel lymph node may not contain cancer while other lymph nodes do. If a surgeon is suspicious during the procedure, other lymph nodes may be removed for pathological examination. If the original or dyed primary cancer has not yet been removed, the surgeon will do so after stitching up the sentinel node biopsy wound. In some cases, the primary has been removed previously, but the surgeon performs a wider excision after the sentinel node biopsy. How much extra tissue is removed depends on the nature and thickness of the original cancer.In most cases, the patient may go home within a few hours of the surgery.After the procedure the blue dye is excreted from the body in the urine, which may appear green for few days. The stain at the excision site fades away over a few months. The radioactive tracer dissipates over a short period of time.Pathology of the sentinel lymph nodeA pathologist examines the sentinel lymph node, sometimes providing a report within an hour or so of the procedure, with the help of frozen sections. However, the report is more accurate if the tissue is fixed and processed in the normal way, which takes at least a day or so to complete. The diagnosis of cancer is not always easy, and special stains and/or other opinions may be required.If the pathologist finds cancer on frozen section, the surgeon may remove other lymph nodes during the same procedure. If it is reported later, this surgery (called completion lymphadenectomy) will be rescheduled for another time. These other nodes may or may not also contain cancer cells. If pathology report is negative, wide excision of the lymph nodes is not necessary.When is sentinel node biopsy unsuitable?Sentinel node biopsy is unsuitable if:There are enlarged lymph nodes on clinical examination There is evidence for metastases at other body sites The patient has previously undergone wide excision of the primary cancer, especially if a flap or graft closure has been used. This is because the lymphatic drainage may have been altered making the procedure inaccurate The primary cancer is on the head or neck, as there are several lymph node clusters close together. It is particularly difficult if the cancer overlies the parotid gland in front of the ear During pregnancy, when radioactive tracer should not be used (blue dye may be acceptable) If there is history of allergy to blue dye. Complications and risks of sentinel node biopsyComplication rates are 10% for sentinel node biopsy, and 37% for completion lymphadenectomy, if required.Delayed wound healing, bleeding from the wound, wound infection, cellulitis, and other complications of sentinel node biopsy are more likely in patients with diabetes, obesity or heart disease, and in smokers. Other risks are listed below.The surgeon may be unable to find the sentinel lymph node. Anaphylaxis can occur, due to allergy to blue dye (

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