The importance of pre-operative axillary ultrasound and intra-operative sentinel lymph node frozen section analysis in patients with early breast cancer – a 3-year study

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COMMENT ON

Sanders MM, Waheed S, Joshi S, Pogson C, Ebbs SR. The importance of pre-operative axillary ultrasound and intra-operative sentinel lymph node frozen section analysis in patients with early breast cancer – a 3-year study. *Ann R Coll Surg Engl* 2011; **93**: 103–105
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There are several things in this communication that cause me deep concern. In Figure 1, it claims that there were 583 breast cancers newly diagnosed during the study period. Out of these, 272 were deemed to be advanced breast cancer or unsuitable for surgery. This is hugely outside any previous publication in this country or for any other country. In general terms, we would have no more than 5% of patients presenting with disease unsuitable for surgical intervention. This invalidates anything that has been said further in this paper.

Furthermore, while the authors are keen to say they are exploring NICE guidelines, they themselves are not adhering to these guidelines. First, NICE explicitly recommends that if sentinel node biopsy is carried out it should be carried out using the triple technique of scintigram, gamma probe and blue dye rather than blue dye alone. Using just blue dye is inaccurate and should not be recommended.

Furthermore, NICE guidance also states that frozen section is not recommended. There are indeed many publications in the literature that show that frozen section of the sentinel node has utility; in other words, when it is positive it is accurate on the whole. However, it has a significant high false-negative rate and therefore has been superseded by other methods such as preliminary change reaction molecular analysis.

Clopidogrel: is a surgical delay necessary in fractured neck of femur?

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COMMENT ON

Nwachuku IC, Jones M; Clough TM. Clopidogrel: is a surgical delay necessary in fractured neck of femur? *Ann R Coll Surg Engl* 2011; **93**: 310–313
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I read with interest this paper that addresses a common orthopaedic dilemma regarding timing of hip fracture surgery in patients on antiplatelet therapy. Clarification of a few points may help myself and other readers.

First, data for type of operation were recorded but not presented. Many would argue that there is significant variation in blood loss among operation types.

Second, the data between Tables 1 and 2 appear incongruous. I would expect the totals for complications and units of blood transfused to be the same in both tables as they are the same patient cohort.

Third, the method of blood loss estimation using pre/post-operative haemoglobin levels has been identified correctly as a limitation of the study. When comparing early versus late surgery, a statistically significant difference in blood loss is described but, given that Table 1 shows the same transfusion rate between groups, is this difference clinically significant?

Last, patients on clopidogrel and dipyridamole only were described. Out of a total of 619 neck of femur fractures, one would expect a large number to be on long-term aspirin. Comparison between matched groups of aspirin and other antiplatelet drugs would have been interesting but most informative of all would be the impact of dual antiplatelet therapy.

Author's response

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I would first like to thank you for your interest in our paper and am very pleased you have taken the time to offer critique and feedback. I aim to respond accurately to each of the various points in turn.