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Regarding the Article “Mixed Choledochal Cyst (Type I and II) Associated With a Malformation of the Pancreatobiliary Junction. A Case Report and Review of the Literature”. Can We Improve the Diagnosis?☆



A propósito del artículo “Quiste de colédoco mixto (tipo I y II) asociado a malformación de la unión pancreatobiliar. Descripción de un caso y revisión de la literatura”. ¿Podemos mejorar el diagnóstico?

Dear Editor:

We have read with interest the article by Dr. Zacarías-Ezzat et al., published in *CIRUGÍA ESPAÑOLA*.¹ The article describes a case of choledochal cyst and reviews the related literature. We feel it is necessary to make some comments on this article.

In the case reported, after a computed tomography (CT) scan of the abdomen showed dilatation of the intra- and extrahepatic bile duct up to the ampullary region, surgical treatment was carried out. The procedure included diverticulectomy, but afterwards a second surgery was required for the necessary bile duct resection. We consider it a very illustrative case that demonstrates once more the need for a correct diagnosis of patients with jaundice to avoid unnecessary or inappropriate surgery. As reported by several studies,^{1,2} when there is cystic dilatation of the bile duct suspected by CT, the diagnosis of choledochal cyst, its type and any possible associated pancreaticobiliary junction anomaly can be confirmed by magnetic resonance cholangio-pancreatography (MRCP), which has a high sensitivity (90%–100%) and specificity (73%–100%). Thus, the management described in the article does not seem to be the most adequate. Furthermore, the authors do not describe the role of MRCP in this situation. Even though MRCP is not

available at all hospitals, we believe that this diagnostic method should be mentioned as it is optimal for avoiding invasive procedures.

We would also like to emphasise that the indication for bile duct resection is considered the gold standard treatment for all type I cysts, and exeresis of the cyst is reserved for type II.^{3,4} Types III to V cysts require a personalised approach, as we have described in our experience with 18 cases published in *CIRUGÍA ESPAÑOLA* in 2008.⁴

Last of all, as the article reports including a review of the literature, we find that both the review and bibliographic references lack the articles we have mentioned,^{2–4} two of which are the most complete reviews published, and our own experience is one of the most extensive national reports.

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Conflict of Interests

The authors have no conflict of interests to declare.

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Micrometastasis in the Sentinel Node in Women With in situ Ductal Carcinoma. False Positives of the OSNA (One-Step Nucleic Acid Amplification) Method?☆



Micrometástasis del ganglio centinela en mujeres con carcinoma ductal in situ. Falsos positivos del método OSNA (One-step nucleic acid amplification)?

Dear Editor:

In a recent article published in your journal, Rubio et al.¹ reported their experience with sentinel node biopsy (SNB) in women diagnosed with ductal carcinoma in situ (DCIS). The article justified this diagnostic procedure because a group of these patients presented metastatic involvement of the sentinel lymph node (SLN), which modified staging and therapeutic planning. Like these authors, our group concurs with the indication of SNB in women with DCIS because the identification of an underestimated infiltrative component in the initial biopsy is justified by the importance of this finding and the low morbidity of the technique. Nevertheless, the introduction of the one-step nucleic acid amplification (OSNA) method for the intraoperative study of SLN has significantly increased the incidence of micrometastases in this group of patients in whom, from an oncological standpoint, metastatisation is not possible as it is a non-infiltrating process. We therefore believe we should report our experience with SLN micrometastases in patients with DCIS to discuss the possible causes and repercussions in therapeutic planning.

In our experience, a total of 8 patients diagnosed with DCIS presented micrometastases in the SNB since we began

implementing the OSNA method in February 2011 until January 2015, without the revisions of the diagnostic biopsies and surgical specimens showing any infiltration/microinfiltration through the basal membrane (Table 1). This represents an incidence of lymph node involvement of 18.4% out of a total of 33 patients diagnosed with DCIS during this time period. The majority of the DCIS (5 out of 8) were high grade, and in 2 patients the micrometastases affected SLN numbers 2 and 3, without evidence of involvement of the first SLN. In the majority of the patients (7 out of 8), the micrometastatic involvement of the SLN did not modify the therapeutic approach, while in one patient the existence of 2 SLN with micrometastases resulted in axillary lymph node dissection (ALND), and the indication of chemotherapy treatment after surgery. In this last patient, no infiltration was observed in the previous biopsies, surgical specimens, or in the axillary fat.

The presence of lymph node micrometastases in patients with DCIS poses 3 possible pathogenic mechanisms. The first would involve undiagnosed infiltration in the breast lesion with metastatic invasion of the SLN detected by the OSNA method. In this situation, the patient would be staged as IB, and adjuvant therapies should be considered. The therapeutic limitation of this situation is centred around the absence of an

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