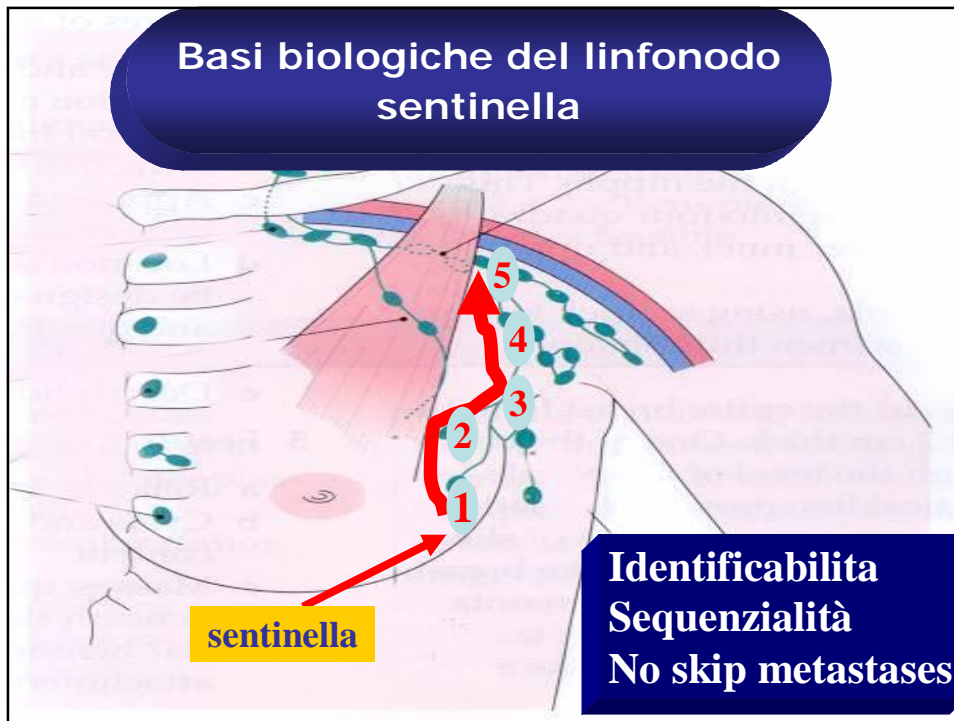




**Breve storia del linfonodo sentinella**

|        |                |                            |
|--------|----------------|----------------------------|
| * 1977 | Cabanas        | (Carcinoma del pene)       |
| * 1992 | Morton         | (Melanoma)                 |
| * 1993 | Krag           | (Ca mammella-radiocol.)    |
| * 1994 | Giuliano       | (Ca.mammella,blù isosolf.) |
| * 1996 | Reintgen e Cox | (Tecnica combinata)        |

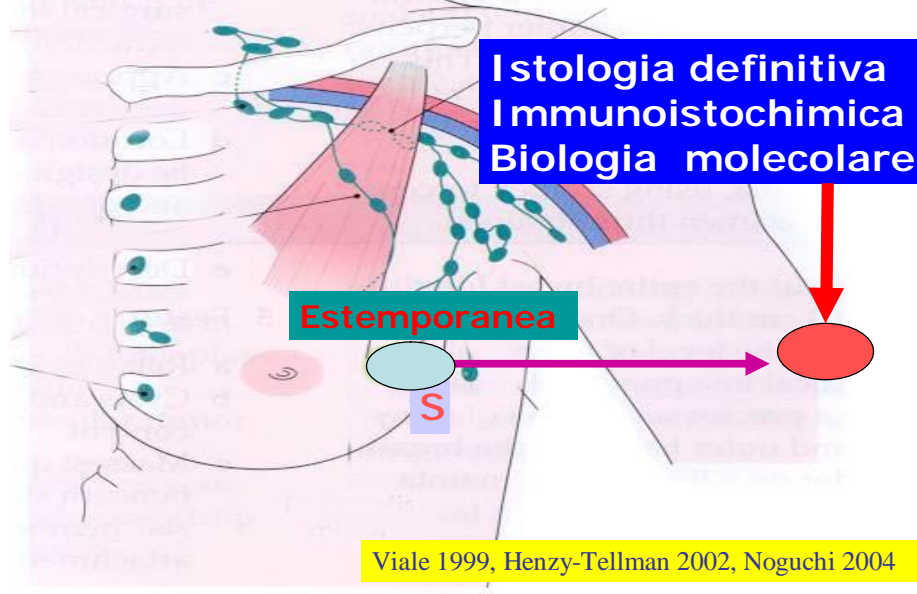


### Tassi di identificazione del linfonodo sentinella

|                   |        |
|-------------------|--------|
| 1997 Borgstein    | 100    |
| 1999 Lincam       | 97     |
| 1999 Kimberg      | 94     |
| 2000 Gail-Molland | 97,5   |
| 2001 McMaster     | 90-98* |
| 2001 Wong         | 86-94* |
| 2002 Bauer        | 90     |
| 2003 Jakub        | 99     |
| 2003 Veronesi     | 99     |

**=In rapporto alla tecnica e al numero dei linfonodi**

## FALSI NEGATIVI ISTOLOGICI : 3-18%



## DIAGNOSTICA DEL LINFONODO SENTINELLA

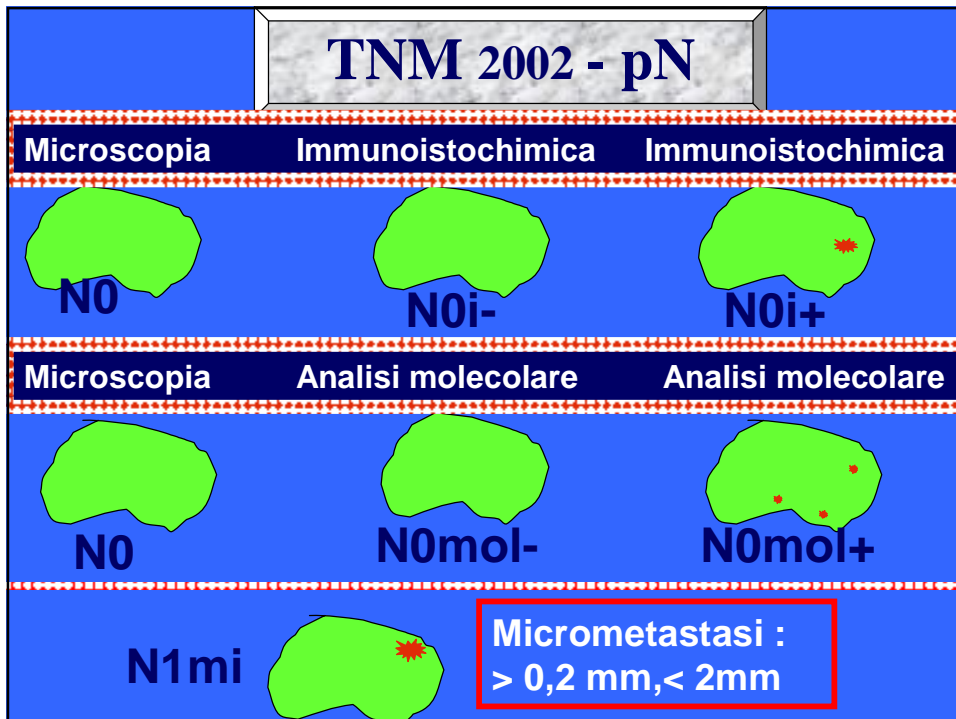
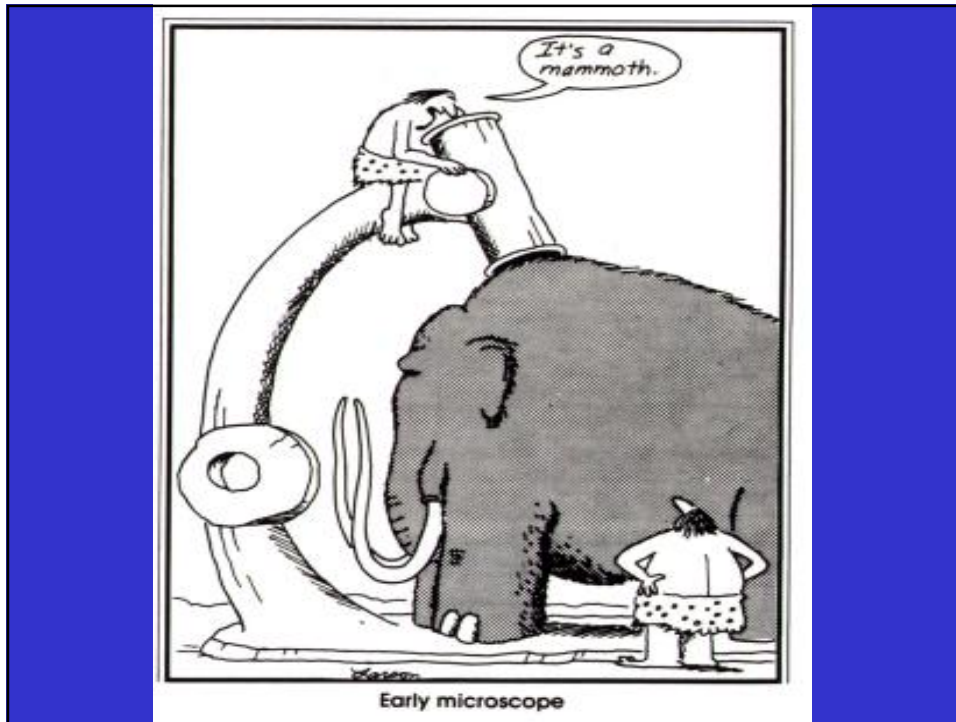
⊕ Clinica

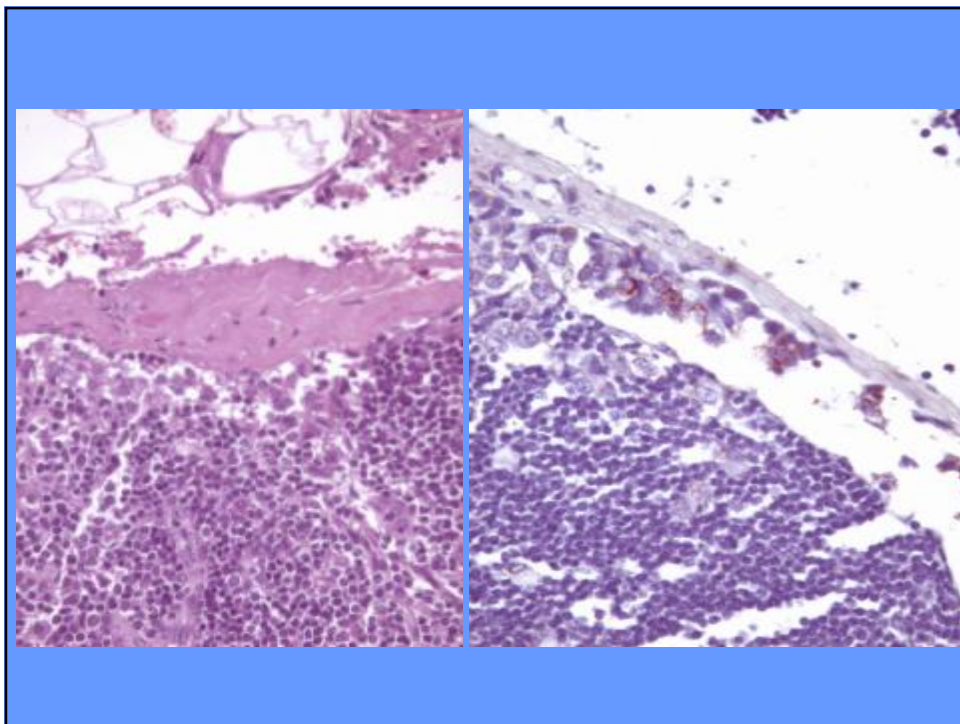
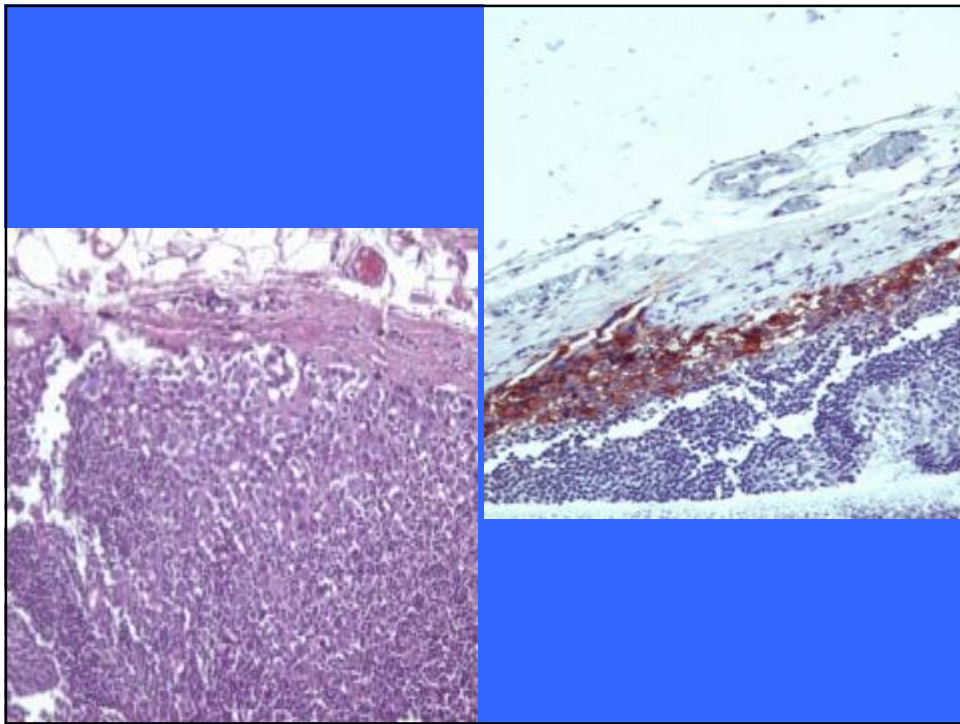
⊕ Estemporanea

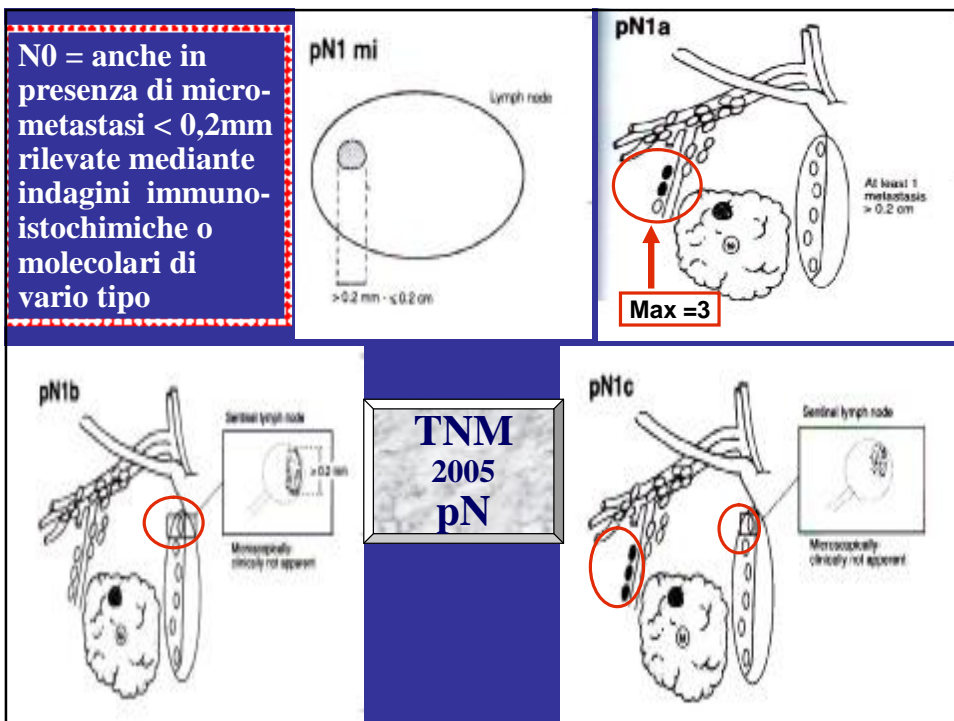
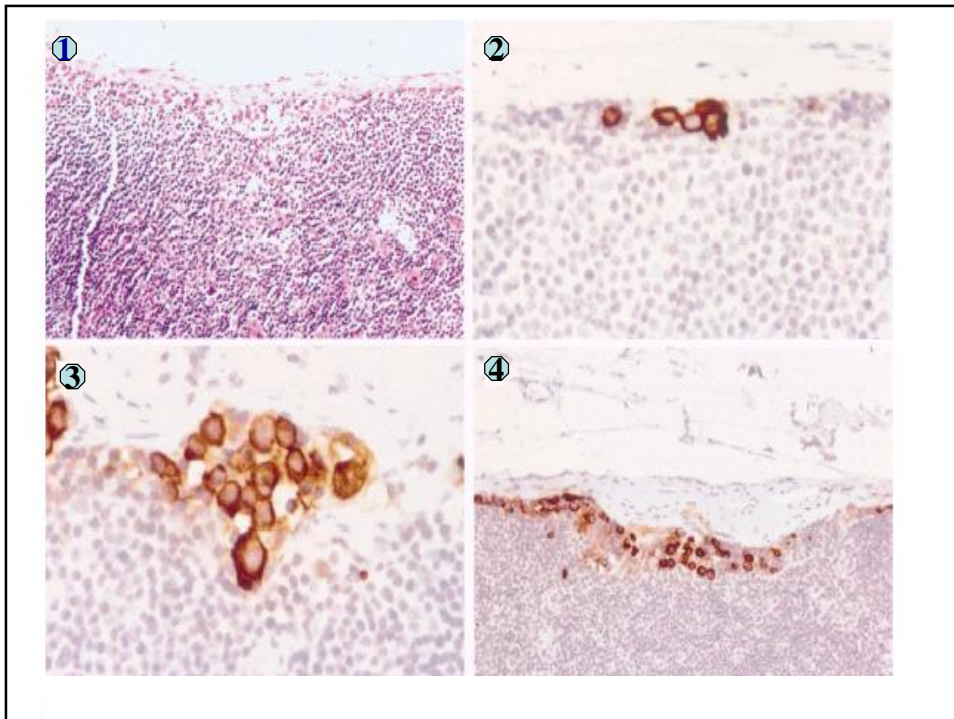
⊕ Es.definitivo 1/10.000

⊕ Immunoistochimica 1/100.000

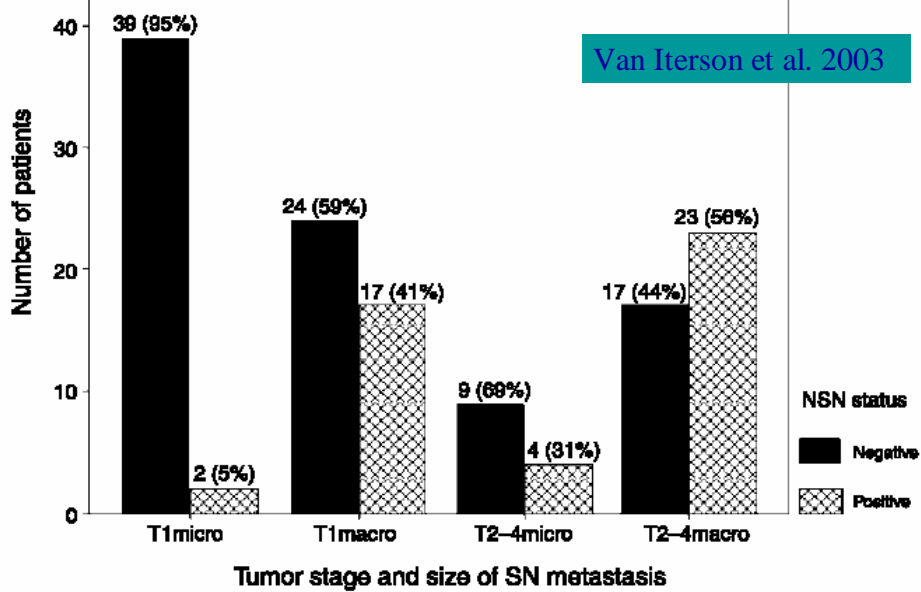
⊕ Biologia Molecolare 1/1.000.000







## METASTASI NEGLI ALTRI LINFONODI ASCELLARI CON SLN+(N1mi, N1)



## INCIDENZA DI METASTASI IN ALTRI LINFONODI IN RAPPORTO ALLE DIMENSIONI DI T E SLN+

| LSN     | T1 <sub>a</sub> | T1 <sub>b</sub> | T1 <sub>c</sub> | T2 | TOTALE |
|---------|-----------------|-----------------|-----------------|----|--------|
| pN0(i+) | 0               | 1               | 3               | 0  | 4/41   |
| pN1(mi) | 0               | 0               | 2               | 4  | 6/71   |
| pN1     | 0               | 10              | 24              | 14 | 48/112 |

Da Dabbs et al. 2004

**SLN [N0 i+] e SN [N0i-]  
Correlazioni con la prognosi e altri parametri**

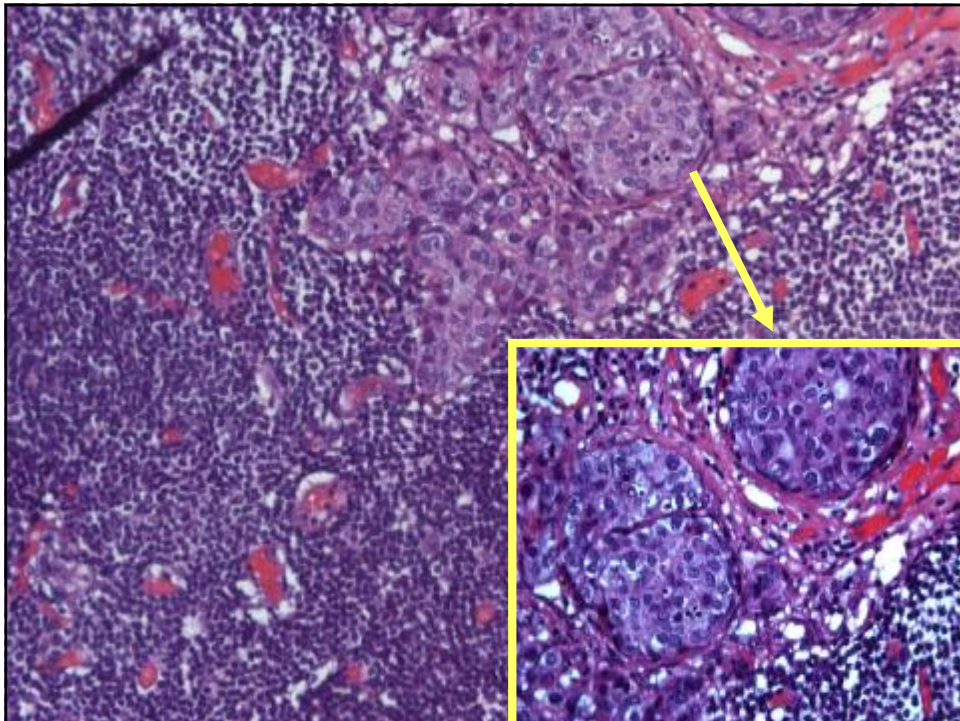
|                           | <b>SLN [N0 i+]</b> | <b>SN [N0i-]</b>   |
|---------------------------|--------------------|--------------------|
| <b>Grado 3</b>            | <b>40%</b>         | <b>43%</b>         |
| <b>ER-negativi</b>        | <b>33%</b>         | <b>33%</b>         |
| <b>Follow-up a 5 anni</b> | <b>100%</b>        | <b>95,7+- 3,0*</b> |

\* = differenze statisticamente non significative

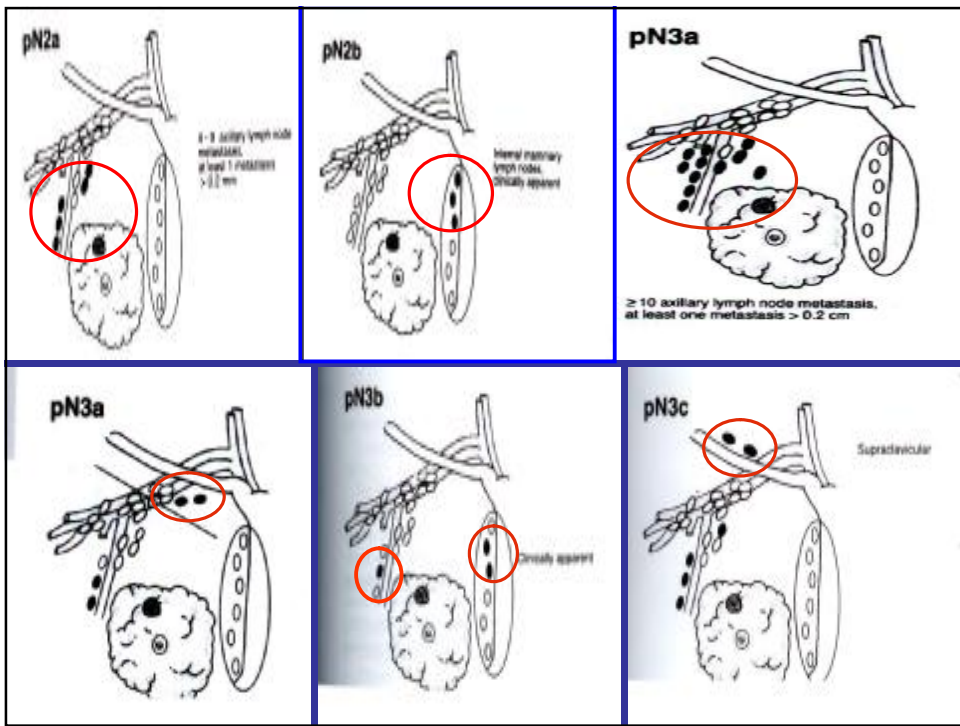
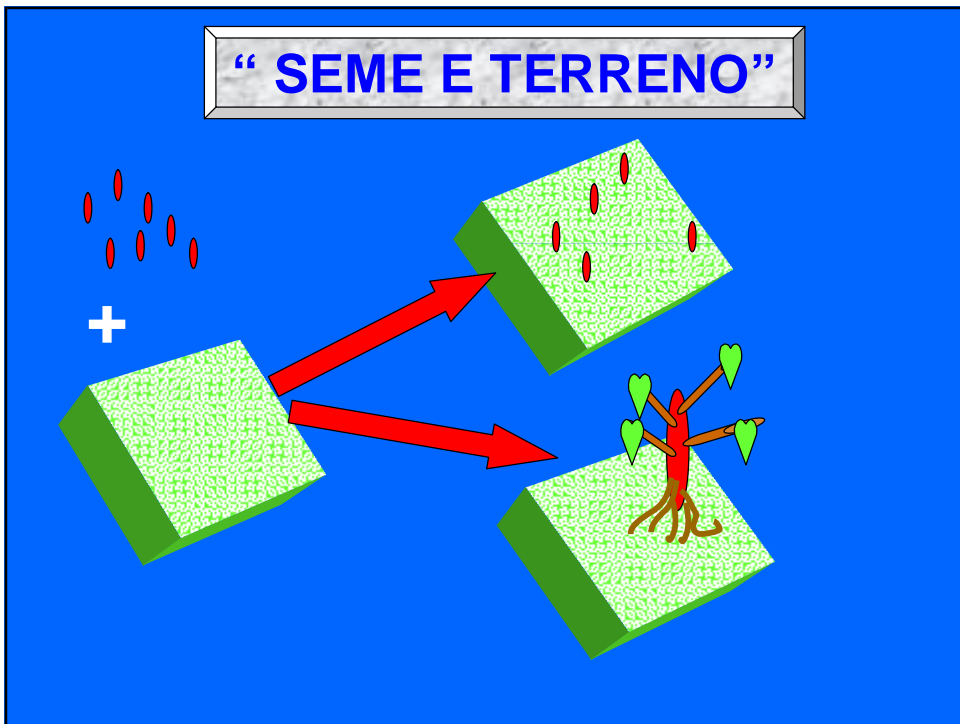
Chagpar et al 2005

**TNM  
2005  
pN**

“Cases with only isolated tumour cells (ITC) in regional lymph nodes are classified as NO. ITC are single tumour cells or small clustered cells, not more than 0,2 mm that are usually detected by immunohistochemistry or molecular methods....ITC do not show evidence of metastatic activity, e.g. proliferation or stromal reaction.”



# “ SEME E TERRENO ”



## PROBLEMI E LIMITI CORRELATI AL LINFONODO SENTINELLA

Falsi negativi : Sottostadiazione, Rimetastatizzazione ?

Tumor dormancy

Embolizzazione e metastasi occulte nel midollo osseo (29% in T1)

Svantaggio prognostico ?

-5% ACOSOG (American College of Surgeons Oncology Group)

-2 % NSABP (National Surgical Adjuvant Breast and Bowel Project)

(Braun 2000, Schmidt-Kittler 2003, Bishoff 2003, Kraus 2003, Chagpar 2005)

### Il "lavoro" della stadiazione per il patologo

