

**LETTER****Priority Claim to “Sentinel Lymph Node Transfer”**Makoto Mihara<sup>1</sup>, Hisako Hara<sup>1,2</sup><sup>1</sup>Department of Vascular surgery, Saiseikai Kawaguchi General Hospital, Saitama;<sup>2</sup>Department of Plastic and Reconstructive Surgery, The university of Tokyo, Tokyo, Japan**Correspondence:** Makoto Mihara

Department of Vascular Surgery, Saiseikai Kawaguchi General Hospital, Nishi-Kawaguchi 5-11-5, Kawaguchi-Shi, Saitama 332-0021, Japan

Tel: +81-48-253-1551, Fax: +81-48-253-1551, E-mail: mihara.plasticsurgery@gmail.com

No potential conflict of interest relevant to this article was reported.

Received: 12 Sep 2015 • Revised: 24 Sep 2015 • Accepted: 24 Sep 2015

pISSN: 2234-6163 • eISSN: 2234-6171

<http://dx.doi.org/10.5999/aps.2015.42.6.788> • Arch Plast Surg 2015;42:788

Copyright © 2015 The Korean Society of Plastic and Reconstructive Surgeons

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

Dear Editor-in-Chief Yong-Ha Kim,

We have read the paper of Nicoli et al. [1] on potential use of transferred lymph nodes as metastasis detectors. It was an interesting case report stating that vascularized lymph nodes that were transplanted after tumor resection could be detectors of tumor metastasis. It also reported the postoperative findings of positron emission tomography—computed tomography to evaluate whether there was a metastasis or not. Although we commend them for their work, we would like to point out that we have already reported the same concept as “sentinel lymph network” reconstruction [2]. In this case report,

we introduced a case of epihypopharyngeal pyriform sinus cancer, for which epi- and mesopharyngeal resection and simultaneous reconstruction were performed. A left superficial circumflex iliac artery perforator (SCIP) flap was used for reconstruction, and the flap contained two lymph nodes. In the pathological examination of the transferred SCIP flap, we found that a greater number of lymphatic vessels were present in the SCIP flap than the anterolateral thigh flap that was taken from another patient (lymphatic vessel endothelial hyaluronan receptor-1 staining). In our case, like Nicoli’s cases, no evidence of metastasis has been detected for 1 year postoperatively.

Nicoli’s paper also presented postoperative indocyanine green (ICG) lymphography findings of one case, in which distally injected ICG flowed into the transferred flap. This showed the lymphatic connection of the recipient site and transferred flap, which should have a profound meaning in terms of the concept of the “metastasis detector” of “sentinel lymph node reconstruction.”

As we stated in our paper, reconstruction of the sentinel lymph node system by lymph node transfer may allow establishment of a system for metastasis screening in cancer recurrence. We hope that this concept will be applied to many other patients in the future and that the technique will be beneficial to them.

**References**

1. Nicoli F, Ciudad P, Lim SY, et al. Potential use of transferred lymph nodes as metastasis detectors after tumor excision. Arch Plast Surg 2015;42:478-83.
2. Mihara M, Iida T, Hara H, et al. Autologous groin lymph node transfer for “sentinel lymph network” reconstruction after head-and-neck cancer resection and neck lymph node dissection: a case report. Microsurgery 2012;32:153-7.