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COMMENTARY

Comment on "Histomorphological Factors Predicting the Response to Neoadjuvant Chemotherapy in Triple-Negative Breast Cancer"

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To the Editor,

I read the article by Jung et al. [1] regarding histomorphological factors predicting the response to neoadjuvant chemotherapy (NAC) in triple-negative breast cancer. They concluded that independent predictors of pathologic complete response after NAC were a higher number of tumor-infiltrating lymphocytes ($p=0.007$), absence of clear cytoplasm ($p=0.008$), low levels of tumor necrosis ($p=0.018$), and high histologic grade ($p=0.039$). However, the authors did not include lymphovascular invasion as a histomorphological factor in univariate and multivariate analyses. Another study tested pathologic complete response to NAC in 324 patients with primary nonmetastatic breast cancer. In this study, multivariable regression analysis identified lymphovascular invasion (odds ratio, 0.05; 95% confidence interval, 0.01–0.18; $p=0.0000$) as a predictive impact in patients with breast cancer receiving NAC [2]. In conclusion, lymphovascular invasion should be evaluated as a predictive factor for patients receiving NAC for triple-negative breast cancer.

CONFLICT OF INTEREST

The author declares that he has no competing interests.

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Author's Reply

We appreciate the comments regarding our recent article titled, "Histomorphological factors predicting the response to neoadjuvant chemotherapy (NAC) in triple-negative breast cancer." The commentary suggested that the lymphovascular invasion (LVI) should be evaluated as a predictive factor for patients receiving NAC for triple-negative breast cancer (TNBC).

In the study by Erbes et al. [1], the authors concluded that LVI is an independent predictive factor for pathologic complete response in patients with breast cancer receiving NAC. In the article, the predictive impact of LVI was evaluated in overall cases regardless of the tumor type, and its predictive impact in TNBC alone was not evaluated.

In previous studies, it was suggested that the TNBC subtype has a lower incidence of axillary lymph node metastases [2]. Furthermore, the lack of a relationship between lymph node involvement and increasing tumor size [3] suggests that TNBC preferentially spread hematogenously [4].

Among 143 TNBC biopsy cases included in our study, only four indicated LVI. This may represent a characteristic of TNBC (preference for hematogenous spread), and statistical analysis was limited owing to the small number of cases. In addition, since our study involved biopsy specimens, the specimen does not represent the entire tumor; therefore, the absence of LVI in the specimen does not confirm the actual absence of LVI in the tumor.

We agree that LVI may be associated with the response to NAC in TNBC. Further studies are required to determine the predictive impact of LVI in TNBC.

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