The contralateral sentinel node

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Identification and dissection of the sentinel node is now standard in the treatment of melanoma. We describe a patient with melanoma of the cheek demonstrating contralateral lymphatic drainage.

Case report

An 85-year-old woman was referred to our surgical oncology office after wide local excision of an intermediate-thickness melanoma of the right cheek. Her medical history was significant for hypertension. She had had no previous problems with her skin and there was no family history. The pathology report revealed a 1.2-mm thick melanoma, extending to one of the inked margins. She was scheduled for wide re-excision and sentinel lymph-node dissection.

Approximately 4 hours before the operation, technetium 99m was injected at the previous excision site in the right cheek (Fig. 1). Nuclear scanning after the injection revealed increased radioactivity on the left side at 2 sites (Fig. 2). In the operating room, 3 mL of isosulfan blue dye was injected at the previous excision site. The blue dye was seen to move medially toward the base of the nose as well as to the buccal area and the angle of the mandible. Scanning intraoperatively with the hand-held gamma counter revealed that the lowest site on the left side of the nuclear scan (Fig. 2) was the point of

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Case notes

Gastrocolic fistula secondary to right gastroepiploic–coronary artery bypass

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Gastrocolic fistula (GCF) generally occurs secondary to chronic peptic ulcer disease. It can be classified as primary or secondary, that is, occurring spontaneously or after operative gastric resection. The patient described here had a GCF occurring as a remote postoperative complication of coronary artery bypass grafting with right gastroepiploic artery.

Case report

A 69-year-old man, a long-term smoker and alcoholic, had a suspected incomplete small-bowel obstruction refractory to an initial course of appropriate nonsurgical therapy. He had presented to the primary care hospital 2 days earlier with a 5-day history of progressive nausea and feculent vomiting with diarrhea, but he had no abdominal pain.

The patient’s medical history included 3 previously documented myocardial infarctions leading to 5-vessel coronary artery bypass 1 year earlier. The right gastroepiploic artery was used as a coronary artery bypass graft. The postoperative course was uncomplicated.

On initial examination, the patient was afebrile and vital signs were stable. He appeared emaciated. His abdomen was moderately distended but soft and nontender. The only evident surgical scar was the epigastric extension of the midline sternotomy incision.

The leukocyte count and hemoglobin level were normal, as were serum electrolyte levels, urea and creatinine values and liver function test results. The serum prealbumin level was low (0.09 g/L). Chest radiography revealed chronic obstructive lung disease. On abdominal radiography there were no obvious intestinal air fluid levels or distended loops.

References


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