Lymph Node Biopsy Service

Usually you will want a lymph node biopsy to make a diagnosis, in order to start treatment.
In some cases this will be because of a high suspicion of malignancy, so it becomes urgent.

A lymph node biopsy is not always required to make the diagnosis. FNA or core biopsy can successfully diagnose many tumours. The main exception is haematological malignancies such as lymphoma, where the node and tumour architecture is important in sub-typing the lesion to best target treatment.

Because nodes are usually adjacent to blood vessels and other vital structures, *the biopsy is almost always performed under general anaesthetic*. This means there may be a degree of risk involved (especially if there are significant comorbidities) that needs to be weighed up against the benefit of obtaining the diagnosis. Broadly speaking, if they are not suitable for a GA, they may not be suitable for treatment of their tumour!

Traditionally, referrals for biopsies have been "ad hoc", with different surgeons or registrars having different availability and enthusiasm to help. For the last few years, I have been acting as the conduit between the Haematology service for all lymph node biopsy referrals. In this way General Surgery can offer a consistent, expedited way of getting biopsies in appropriate patients.

Usual Pathway to Obtain Biopsy

You see a patient who you think may have lymphoma.

You decide you need a biopsy. You discuss the patient with your Haematology consultant.

Ask yourself three questions:
1) Is there ANY chance this could be another tumour?
2) Is the lesion easily palpable, or only seen on imaging?
3) Are they very healthy, or do they have what might be significant anaesthetic risks?

Obtain an FNA, unless 1) is "no". An example would be a known lymphoma patient who has developed clinical nodal recurrence in the absence of other malignant disease.

> Ideally do the FNA yourself, there and then in the clinic. Alternatively, request it through Pathology, although this will build in a delay for further action.
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> (The FNA is required to exclude other malignancies, such as adenocarcinoma (breast, colon, lung), squamous carcinoma (tongue/throat, anal), or melanoma. Some of these diseases will need treatment where a biopsy incision will jeopardise subsequent care).
>
> FNA will not diagnose lymphoma, but it doesn't have to!

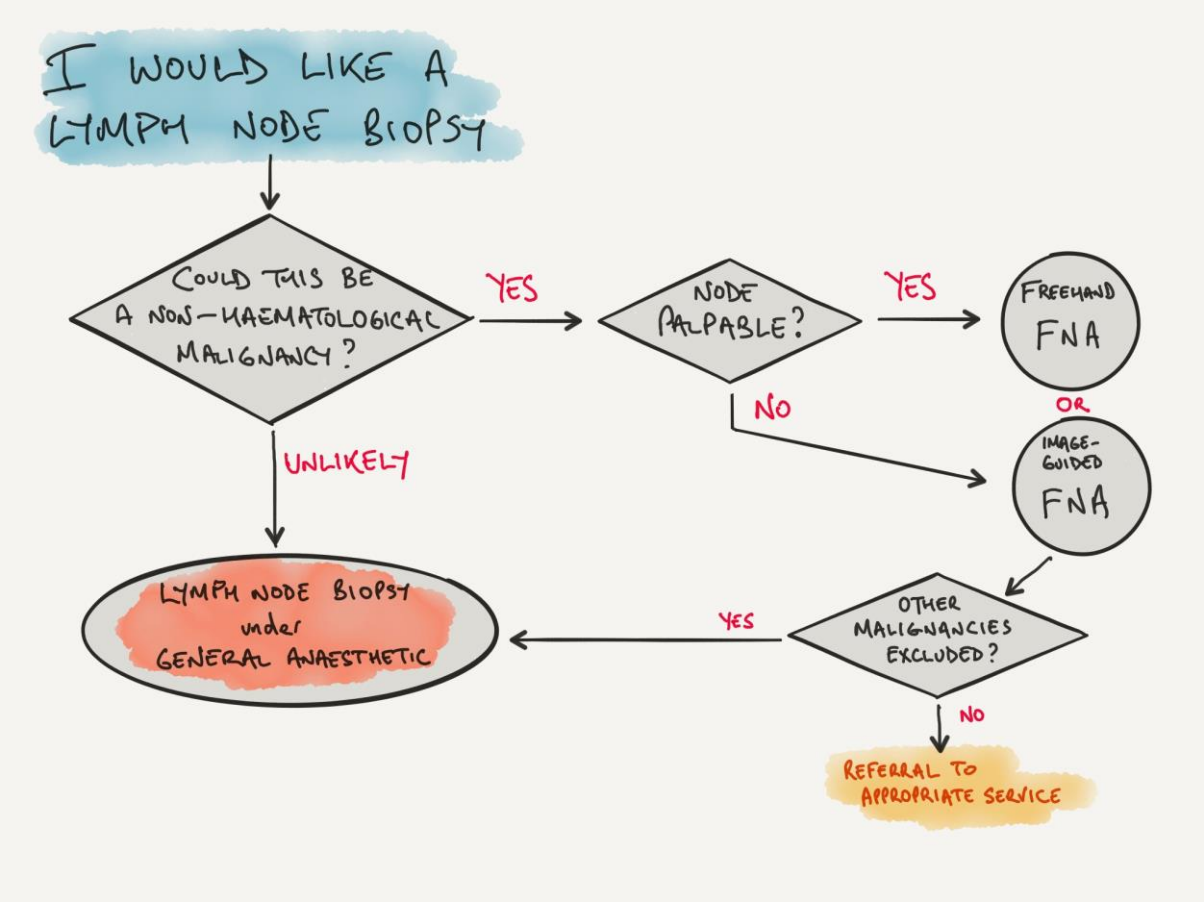
Determining whether the lesion palpable or not will determine our surgical approach.
Deep/impalpable lesions can be challenging, especially in the neck (and in this case, I usually ask Dr

Andrew Cho from ORL/ENT to perform the biopsy). Please do not overestimate how palpable things are; if the findings are subtle, we need to know and may request imaging as backup.

Finally, your **determination as to their overall health and suitability for GA** is important. Anyone considered above low risk should probably be preassessed in our clinic. Cancelling a patient on the day of operation is a huge waste of resource and source of frustration!

Once you have asked these questions, email me with the request for biopsy and the answers!

I'll attempt to prioritise all patients, with urgent cases biopsied on a planned elective operating list within two weeks where possible. (If things are critical, we will sometimes consider acute biopsies).



Matthew Clark
General Surgeon and Surgical Oncologist
Clinical Associate Professor
021 057 9107
matthew.clark@middlemore.co.nz