resection of the medial lymph nodes (level II) involve medial retraction and potentially injury to the median pectoral nerve. Injury to either, or to the long thoracic and thoracodorsal nerves, is much less likely with the more recent use of sentinel node biopsy (selective axillary lymph node sampling) for the majority of breast cancer surgeries. Sentinel lymph node biopsy became a standard part of breast cancer surgery worldwide in the early 2000s and has therefore not been included in most publications in the literature regarding PMPS, although there is some emerging work demonstrating that the sentinel node axillary sampling procedure is a significant protective factor for the development of PMPS.[5]

In order to move forward in better understanding and quantifying PMPS among breast cancer patients, the syndrome does need a unifying definition; however, further prospective work is needed in order to understand PMPS more as an axillary pain syndrome. The prevalence of PMPS has likely already diminished substantially with the use of sentinel node biopsy for axillary staging in patients with breast cancer and may become less of an issue as clinical trials continue to expand the indications for sentinel node biopsy among patients with positive clinical lymph nodes after neoadjuvant chemotherapy.

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Correction

There was an error in Figure 2 of the article by Stewart and colleagues[1] published in the August 2016 issue of *CJS*. The graphs were mislabelled in panels A to D. A corrected version of the article is available on our website at canjsurg.ca. We apologize for the error.

Reference

1. Stewart JM, Tone AA, Jiang H, et al. The optimal time for surgery in women with serous ovarian cancer. *Can J Surg* 2016;59:223-32.