Surgeons in our unit operate on approximately 300 cancers in a year. We therefore conducted a prospective study to see if this policy impacted on our operating time.

Material and Method: 32 cases since December 2007 have been included in this study. Start and finish times of each operation was recorded. The time when sentinel node was sent to the laboratory and time when results were received were recorded. The number of blue nodes sent was noted. Sentinel nodes were identified using 2 mls of 2.5% Patent Blue injected in the subareolar plane. The lymph node was sent for assessment while wide local excision was carried out. Wounds were closed while waiting for the result. If axillary disease was confirmed the axilla was reopened and axillary clearance completed. Frozen section of the sentinel node was done. Nodes less than 5 mm were sectioned whole. Nodes between 5−10 mm were bisected then cut as larger nodes. Nodes more than 10 mm were cut into 3 slices, each slice step-sectioned in normal 1 mm steps, 2/3 sections taken at each step.

Results: 32 cancers were operated on in the study period. Sentinel nodes was retrieved in all cases. A total of 45 sentinel nodes were sent for frozen section analysis. 5 cases had positive lymph nodes requiring axillary clearance. Mean operating time was 60 minutes (range 35–120 minutes). Mean times for frozen section result was 35 minutes.

Conclusion: Frozen section of sentinel node does not impact on the overall operating time and theatre utilisation remains the same. At the present moment we are conducting an ongoing study to establish the role of frozen section of blue nodes in the management of axillary disease in breast cancer.

References

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375 Poster

Sentinel node biopsy for nonpalpable breast tumors after previous breast surgery – preliminary results

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Sentinel lymph node biopsy (SLNB) is an alternative to complete axillary lymph node dissection (ALNB) in clinically node-negative breast cancer patients. A previous breast biopsy has been considered a relative contraindication to SLNB. This study evaluate the accuracy of SLNB by following the axillary relapses after the procedure in patients who had undergone a breast biopsy before SLNB.

Up to January 2008 nine patients with the diagnosis of nonpalpable invasive breast cancer underwent SLNB after an excisional biopsy. The patients were submitted to SLNB by lymphoscintigraphy and isosulfan blue dye performed periareolar (lymphoscintigraphy) and in the biopsy area (blue dye). We follow these patients every six months focusing on the research of axillary relapse of disease.

In seven of cases the sentinel node was negative. In two of cases the sentinel node was positive. The sentinel node was identified in 100% of cases. The follow up period is eighteen months. There is no axillary lymph node relapse.

SLNB after an excisional biopsy with lymphoscintigraphy and blue dye for evaluation of the axilla can be considered a standard procedure.