



ST. JOHN HEALTH BREAST CARE PROGRAM

STANDARD 1.2: SENTINEL LYMPH NODE BIOPSY

Standard of Care:

Eligible patients with either 1) invasive breast cancer with clinically or histologically (i.e., FNA of lymph node) negative axillary nodes; or 2) DCIS who are undergoing a planned mastectomy can expect to receive a sentinel lymph node biopsy (SLNB) to determine extent of disease.

Potential exclusions for this procedure are as follows:

- Pregnant or lactating;
- Reduction mammoplasty;
- Inflammatory breast cancer;
- Known axillary metastasis;
- Previous ipsilateral axillary surgery;
- Previous ipsilateral breast surgery (extensive excision in UOQ);
- Palpable ipsilateral lymph nodes;
- Small DCIS lesion treated with lumpectomy (NCCN guidelines);
- T4 tumors (ASCO guidelines);
- Neoadjuvant breast cancer treatment based on surgeon discretion (ASCO guidelines);
- Sentinel node not identified at time of operation.

Standard of Practice:

- Surgeons providing breast care services should be adequately trained in the SLNB procedure;
- Pathologists evaluating sentinel lymph node specimens should be experienced and strive to employ common methodology and reporting criteria;
- Eligible patients (as discussed above) should be offered a sentinel lymph node biopsy as the procedure of choice for determining axillary status;
- Surgeon documentation should reflect ineligibility factor(s) of patients for a SLNB or reason eligible patients did not receive this procedure;
- Axillary lymph node dissection (ALND) should be completed for patients with micro metastases (>0.2 mm but ≤ 2.0 mm) and/or macro metastases (≥ 2.0 mm) found on SLNB unless patient refuses or at physician discretion (based on individual patient circumstances which requires documentation).

Potential Benefits of Procedure:

- SLNB is associated with fewer complications such as infection (cellulitis) of the chest wall and arm, sensory changes and lymphedema than conventional ALND.
- As current data reflects a 25% positivity rate in axillary nodes for all breast cancer patients, a SLNB could possibly prevent the use of an ALND and its associated complications in the majority of patients.

References:

For staging patients with invasive breast cancer, sentinel lymph node dissection (SLND) is a minimally invasive alternative to axillary lymph node dissection (ALND). As confirmed by multiple studies drawn from a wide range of practice settings, the staging accuracy of SLND, properly performed, is at least equal to that of ALND (occasional false negatives offset by improved detection), and the morbidity is less. For these reasons, SLND has become the preferred practice for most surgeons who treat breast cancer. [The American Society of Breast Surgeons, December 8, 2005]

Sentinel lymph node biopsy (SLNB) is the preferred method of axillary lymph node staging if there is an experienced sentinel node team, and the patient is an appropriate SLNB candidate. Results of randomized clinical trials indicate that there is a lower risk of morbidity associated with sentinel node mapping and excision than with level I/II axillary dissection. [National Comprehensive Cancer Network, January 28, 2008]

Sentinel lymph node biopsy (SLNB) is an appropriate initial alternative to routine staging axillary lymph node dissection (ALND) for patients with early stage breast cancer with clinically negative axillary nodes. Completion ALND remains standard treatment to patients with axillary metastases identified on SLNB. Appropriately identified patients with negative results of SLNB, when done under the direction of an experienced surgeon, need not have completion ALND. Isolated cancer cells detected by pathologic examination of the sentinel lymph node with use of specialized techniques are currently of unknown clinical significance. Although such specialized techniques are often used, they are not a required part of sentinel lymph node evaluation for breast cancer at this time. Data suggest that SLNB is associated with less morbidity than ALND, but the comparative effects of these two approaches on tumor recurrence or patient survival are unknown. [American Society of Clinical Oncology, September 12, 2005]

Percentage of eligible breast cancer patients undergoing sentinel node biopsy should be at a 100% rate. [Oncology Roundtable, The Advisory Board Company, 1999]

Attested that this standard was reviewed and approved by the St. John Health Breast Care Advisory Board on: 3/11/09.

Cheryl A. Wesen Dated: 3/19/09
Cheryl A. Wesen, MD, FACS
Medical Director, St. John Health Breast Care Program