



Consensus Statement on Guidelines for Performing Sentinel Lymph Node Dissection in Breast Cancer

This statement updates the Original Guidelines (November 1998), First Revision (August 2000), Second Revision (November 2002), Third Revision (October 2003), Fourth Revision (December 2005).

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 of SLND is less. For these reasons, SLND has become the preferred practice for most surgeons who treat breast cancer.

1) Indications and contraindications:

Early reports notwithstanding, the current body of reported surgical experience shows that SLND is suitable for virtually all clinically node-negative T1-3 invasive breast cancers, including patients with multifocal/multicentric disease and prior breast surgery. More limited - but reasonable - data suggest that SLND is feasible following axillary surgery of minimal extent, especially a previous SLND, following radiotherapy, and following neoadjuvant chemotherapy. The decision to apply SLND in these situations requires individualized surgical judgement and fundamentally requires an unequivocally successful mapping procedure. If the identification of a sentinel node is in doubt by established technical criteria, standard axillary dissection is advised. SLND should be considered for DCIS whenever mastectomy is required or when invasive disease is suspected. The role of SLND for inflammatory breast cancer remains undefined.

2) The positive SLN:

Outside of clinical trials, usual treatment for SLN-positive patients is a level I-II ALND. However, since axillary node metastases are limited to the SLN in more than half of SLN-positive individuals, there may be low-risk subsets for whom a completion ALND is not required. The decision to omit completion axillary dissection in such a case requires a balanced discussion between the surgeon and the patient regarding the risks of further surgery and any potential for improved outcome with more complete information and/or axillary clearance.

3) Credentialing and privileging:

The credentialing and privileging of SLND should be done in accordance with the policies and procedures of each local hospital. The best available retrospective data suggest that 20 SLND procedures validated by an ALND (or mentored by an experienced colleague) are optimal to minimize false-negative results, and we recommend obtaining this level of



experience before performing SLND on its own. However, the learning curve for SLND may not be this long: recent prospective data show that for surgeons using a well-standardized technique, the learning curve for SLND may be much shorter, with most failed results occurring in the first few cases done.

4) Technique:

The success of SLND is maximized, and the false-negative rate minimized, by a technique which combines careful intraoperative digital examination, blue dye and isotope mapping. Sentinel node staging programs with the lowest false negative rates report an average yield of two sentinel nodes per dissection (some cases with less some cases with more).

5) Morbidity and long-term results:

The morbidity of SLND (including lymphedema), while significantly less than that of ALND, is not zero. However, axillary recurrence after a negative SLND has to date proven to be a very rare event. We encourage all surgeons performing SLND to track their long-term results by contributing to local or national registries, and by enrolling their patients in clinical trials.

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Board of Directors
The American Society of Breast Surgeons