SUMMARY

Breast cancer is the most common malignant diseases in females accounting for 27-30% of their malignancies. It affects 1 in 14 women during their life time. Great strides have beenmade in the treatment of breast carcinoma that have reduced the risk of recurrence and improved survival rates. Thus, breast cancer is considered a chrnic illness requiring ongoing care and monitoring with greater emphasis on symptom management, quality of life, and the expectation on the part of patients, their families, and caregivers that the patient with attempt to maintain as normal a life style as possible.

However, there are no prognostic signs or tests that can accurately predict the occurrence of axillary lymph node metastasis. Because axillary metastasis is the most important prognostic indicators in early breast cancer, and of particular value in the choice of adjuvant therapy, axillary lymphadenectomy remains the gold standard for staging by histo-pathological examination of axillary lymph nodes, but the need for and extent of axilary lymph node dissection (A.L.N.D.) is controversial, whilst the value of AL.N.D. in loco-regional control is beyond dispute, it does not seems to have a significant effect on long-term survival, and also, add a relative morbidity of the various surgical axilary dissection procedures. The sentinel lymph node, which is the first node to receive lymph from the involved breast area, looks to be able to provide the solution to this dilemma.

In this work 60 patients with Multi contenic and Multi focal invasive breast cancer and clinically mode negative underwent SLN biopsy and lymphatic mapping technique by blue dye and/or gamma ray dector probe.

As the result from this work 9 false negative cases (15%) with SLN accurately predicted 85% and specificity = 65% sensitivity 67%.

So, it was shown that patients with upper outer Quadnant (UOQ) with T2 tumour size, had the highest detection rate and more accurate in sentinel lymph node mapping technique.

CONCLUSIONS

Sentinel lymph node dissection (S.L.N.D.) can accurately determine the presence or absence of axillary nodel metastases. In this trial it showed that sentinel lymphadenectomy can accurately the first axillary lymh node 'sentinel lymph node' draining the primary tumour, which is the node most likely to contain tumour cells that have spread to the axilla. The sentinel lymph node technique could enhance staging accuracy, and with further modification and experience, might alter the role of axillary lymph node dissection. The procedure is minimally invasive and avoids the complications of axillary lymph node dissection (A.L.N.D). all details of the procedure, from nuclear medicine to the surgical procedure and pathology, should be harmonized so that successful results can be achieved.

The most important results that should be established t each institutionis the false negative rate. This is only accomplished by a follow (A.L.N.D.) immediately after (S.L.N.D), regardless of the sentinel node histopathology, and to gain the maximum benefit from the procedure it has been advocated to perform a meticulous selection of patients to reach the least false negative rate, with a higher detection rate in patients with lowest incidence of lymph node metastases.

SLN biopsy has pnoved to be an accurate alternative to complete axillary lymph node dissection. Mc Mf invasive breast cancer, are considered to be relative contraindication to S.L.N.B.