authors of the present study in our hospital. Of these 630 patients, 529 patients underwent SLNB during their surgery, along with mastectomy or lumpectomy. We performed SLNB using a blue dye in 83 patients, a combination of blue dye and radioisotope in 341 patients and a combination of blue dye and SPECT in 105 patients. We did not distribute the patients intentionally; the methods were chosen by circumstances in our hospital on the basis of the delivery of technetium or the rejection of SPECT by the patients. We evaluated each method using the number of lymph nodes resected in each surgery and the number of patients with metastasis.

Result: The mean number of SLNs detected using each method is as follows: 1.56 using only the blue dye, 1.62 using a combination of the blue dye and radioisotope and 1.58 using a combination of the blue dye and SPECT. The numbers of patients who had metastasis in their SLNs in each group were 12 (9.2%), 55 (9.9%) and 22 (11.4%) respectively. The percentage of patients who underwent lymphadenectomy of nodes not identified by dye staining or radioisotope spots were 48.2%, 41.1% and 25.7% respectively. There were no significant differences in surgical time, bleeding or other complications among the groups.

Conclusions: SPECT had a significant impact, resulting in the resection of fewer lymph nodes among the three groups. We conclude that SPECT may be beneficial for SLNB by reducing the number of lymph nodes that we resect during the surgeries.

Results: The sentinel node was identified in 100% of patients. In 4 of the 10 patients the sentinel node was positive. These patients went on to have an axillary clearance and avoided a second operation under general anaesthetic. There were no complications.

Conclusion: Obtaining sentinel node histology is feasible with excision of nodes under local anaesthetic and may be considered in planning breast cancer surgery.

No conflict of interest.

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<table>
<thead>
<tr>
<th>Table</th>
<th>Blue dye only</th>
<th>Dye and radioisotope</th>
<th>Dye and SPECT</th>
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<tr>
<td>The mean numbers of SLN</td>
<td>1.56</td>
<td>1.62</td>
<td>1.58</td>
</tr>
<tr>
<td>The rates of patients with metastasis in their SLN</td>
<td>9.2%</td>
<td>9.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>The rates of patients who got extra lymphadenectomy</td>
<td>48.2%</td>
<td>41.1%</td>
<td>25.7%</td>
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</tbody>
</table>

No conflict of interest.

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467. Morbidity after sentinel lymph node biopsy in primary breast cancer patients

Y. Kallos1, I. Papapanagiotou2, T. Piperos2, I. Flessas2, M. Zoulamoglou1, E. Konstantinou2, K. Theodoulou3, T. Mariolis-Sapsakos3

1 Naval and Veterans Hospital of Athens, Department of Surgery, Athens, Greece
2 Evgenideion Hospital, Department of Surgery, Athens, Greece
3 “Mitera” Hospital, Department of Surgery, Athens, Greece

Background: Sentinel lymph node biopsy (SLNB) is currently the preferred method of staging the axilla in primary breast cancer patients with clinically negative axillary lymph nodes, replacing standard axillary lymph node dissection (ALND), and thus avoiding its high morbidity rates. However, as an invasive technique, SLNB still carries a risk of postoperative complications. The purpose of this study is to analyze the complications of the use of SLNB in primary breast cancer patients.

Materials and methods: 142 patients with mean age of 54.6 years underwent SLNB for primary breast cancer between the years 2007–2013 in two institutions by two surgical teams. In order to localize the sentinel lymph node, blue dye was used in 38/142 patients and blue dye plus radioactive colloid in the remaining 104. We recorded and analyzed the operative notes as well as the early and late complications of the procedure.

Results: The localization of at least one SLN was successful in all patients. A mean of 2.46 lymph nodes were excised (range 1–5). Frozen section of the SLN was positive in 46/142 patients, who subsequently underwent ALND and were excluded from the present analysis. SLNB was false negative in 1/96 patients. Five patients developed a seroma, while prolonged blue staining of the skin was observed in two patients. All patients reported normal mobility of the ipsilateral arm in their 6-month follow up. There were no cases of anaphylaxis due to the blue dye or the radioactive colloid. There were no cases of lymphedema, hematoma, sensory or motor nerve damage.

Conclusions: The status of the axillary lymph nodes is one of the most important prognostic factors in women with early stage breast cancer. SLNB has replaced ALND as the standard technique for axillary staging in patients undergoing surgery for breast cancer, leading to a significant reduction in physical morbidity, by eliminating the need of ALND in patients with negative SLNs. SLNB is a safe technique, with only mild or moderate severity complications.

No conflict of interest.

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