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conservation procedures (conventional or oncoplastic). Out of this group, 53 patients had tumour size 0.1 to 3.0 cm. Out of this 22 were T1 and 31 were T2 (up to 3 cms). When immunohistochemical profile is taken in consideration, 12 patients are excluded for being HER2 enriched, triple negative or Luminal B HER2 positive.

In the remaining group of 41 patients, 12 patients (29.3%) had sentinel nodes reported metastatic on frozen section, 9 being macrometastases and 3 being micrometastases. Completion axillary dissection was carried out in all 12 patients at the same time. Only 1 out of these 12 patients had additional tumor deposit in the non-sentinel nodes. Of the patients with macrometastases or single macrometastasis (7 patients), none had non-sentinel node involvement. Of the remaining 5 patients with 2 or 3 nodes involvement in sentinel nodes, 1 patient had micrometastatic involvement of a single non-sentinel node.

Conclusions: In this cohort of patients undergoing SLNBx at our hospital, patients with tumors up to 3 cms in size, Luminal A or Luminal B HER2 negative IHC profile and undergoing breast conservation surgery constituted 25% (41/164) of all patients having SLNBx. Out of these, patients with macrometastases or single macrometastasis in the sentinel node on frozen section did not have non sentinel node metastases and can be safely considered for omission of completion axillary dissection. This would affect the treatment of 7 patients out of this cohort of 164 patients. With progressively earlier diagnosis, this ratio should improve.

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