Date: 1405/08/16, 2026/11/07

Patient's Name: B.A

Responsible Physician: Dr.Mahdavi

Patient Presentation:

A 54 Y/O female

Invasive ductal carcinoma (IDC) of the right breast, initially presenting as a 25 mm mass. Both the breast mass and an axillary lymph node were marked (clipped) prior to treatment.

Receptor status / biomarkers:

-ER: positive

-PR: positive

-HER2: positive (IHC 3+)

-Ki-67: 10-12%

Treatment to date: The patient received neoadjuvant chemotherapy. Following treatment, the breast mass was not identified on ultrasound, and the axillary lymph node had a normal appearance with a cortical thickness of 2 mm. She then underwent wire-localized breast-conserving surgery (BCS) with sentinel lymph node biopsy (SLNB), together with left mammoplasty.

Pathology findings:

-Residual disease: multifocal IDC with nine foci around the marker site, each smaller than 1 mm. Histologic grading could not be determined because of the very small size of the residual foci.

-Lymphovascular invasion (LVI): not identified.

-Surgical margins: negative.

-Residual Cancer Burden (RCB): class II. Final residual tumor bed dimensions are 17 mm and 9 mm.

-Sentinel lymph nodes: two nodes were examined.

- Intraoperative frozen section: both nodes negative for metastasis.

- Final (permanent) pathology: one node free of tumor, and one node with a micro metastasis measuring 1.2 mm.

Intraoperative the patient developed severe arrhythmia with a reduction in left ventricular ejection fraction (EF). She was admitted to the coronary care unit (CCU), where trigeminal premature ventricular contractions (PVCs) were noted, and she subsequently underwent catheter ablation.

Question:

Is completion axillary lymph node dissection (ALND) indicated, or is adjuvant radiotherapy sufficient for management of the axilla?

Recommended Plan:

- ✓ Axillary ultrasound should be performed. If there is no evidence of lymphadenopathy, completion ALND is not required, and the patient should proceed to adjuvant radiotherapy.
- ✓ If lymphadenopathy is present, surgical management (axillary dissection) is recommended.

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