PREOPERATIVE DIAGNOSIS,Left breast ductal carcinoma in situ.,POSTOPERATIVE DIAGNOSIS,Left breast ductal carcinoma in situ.,PROCEDURES PERFORMED,1. Sentinel lymph node biopsy.,2. Ultrasound-guided lumpectomy with intraoperative ultrasound.,ANESTHESIA,General LMA anesthesia.,ESTIMATED BLOOD LOSS,Minimum.,IV FLUIDS,Per anesthesia record.,COMPLICATIONS,None.,FINDINGS,Clip well localized within the specimen.,INDICATION,This is a 65-year-old female who presents with abnormal mammogram who underwent stereotactic biopsy at an outside facility, which showed atypical ductal hyperplasia with central necrosis. On reviewing this pathology, it is mostly likely DCIS. The risks and benefits of the procedure were explained to the patient who appeared to understand and agreed to proceed. The patient desired MammoSite Radiation Therapy; therefore, the sentinel lymph node biopsy was incorporated into the procedure.,PROCEDURE IN DETAIL,The patient was taken to the operating room, placed in supine position, and general LMA anesthesia was administered. She was prepped and draped in the usual sterile fashion. Prior to the procedure, she underwent nuclear medicine injection with technetium-99 and methylene blue. Incision was made of the area of great uptake and the axilla and taken through the subcutaneous tissue with electric Bovie cautery. Two sentinel lymph nodes were identified, one was blue and hot and the other was just hot. These were sent to Pathology for touch prep. Adequate hemostasis was obtained. The wound was packed and

attention was turned to the left breast. Ultrasound was used to identify the marker and the mass within the breast and create an adequate anterior skin flap. An elliptical incision was made roughly at approximately the 3 o'clock position secondary to subcutaneous tissues with electric Bovie cautery. The mass was dissected off the surrounding tissue using Bovie cautery down to the level of the pectoralis fascia, which was incorporated within the specimen. The specimen was completely removed and marked **** double deep, and a mini C-arm was used to confirm this. The marker was well localized within the center of the specimen. The fascia was then elevated off of the pectoralis muscle and closed loosely with the interrupted 2-0 Vicryl sutures to create a nice spherical cavity for the MammoSite radiation catheter. The wound was then closed with a deep layer of interrupted 3-0 Vicryl followed by 3-0 Vicryl subcuticular stitch and 4-0 running Monocryl. The axillary wound was closed with interrupted 3-0 Vicryl and a running 4-0 Monocryl. Steri-Strips were applied. The patient was awakened and extubated in the OR and taken to PACU in stable condition. All counts were reported as correct. I was present for the entire procedure.