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| Navn – CPR-nr. | Sygehus, afd. |
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Vejledning: Skemaet udfyldes af kirurgisk afdeling ved enhver operation med sentinel node (SN).
SN skema indtastes online via DBCG's hjemmeside (www.dbcg.dk)

| <input type="checkbox"/> SN i forbindelse med præoperativ klassifikation <input type="checkbox"/> SN efter neoadj. medicinsk behandling | Frysemikroskopi på SN <input type="checkbox"/> Ja <input type="checkbox"/> Nej | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------------|-----------|-------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---|--|--|--|--|--|--|--|--|--|--|
| Indikation <input type="checkbox"/> Invasiv c.m. Unifokal <input type="checkbox"/> Invasiv c.m. Multifokal/ Multicentrisk <input type="checkbox"/> In situ | <input type="checkbox"/> Nej <input type="checkbox"/> Højre <input type="checkbox"/> Venstre | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tidligere indgreb <input type="checkbox"/> Præoperativ excisionsbiopsi forud for SN <input type="checkbox"/> Operation i pågældende bryst Angiv operationsår: _____ Lokalisation af tidligere indgreb <input type="checkbox"/> Øvre lateral <input type="checkbox"/> Øvre medial <input type="checkbox"/> Nedre lateral <input type="checkbox"/> Nedre medial <input type="checkbox"/> Central | Aksilrømning i samme seance <input type="checkbox"/> Ja <input type="checkbox"/> Nej Årsag til aksilrømning <input type="checkbox"/> Valideringsfase <input type="checkbox"/> Som følge af frysemikroskopisvar på SN <input type="checkbox"/> Mistanke om metastaser ved operationen <input type="checkbox"/> SN ikke fundet | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injektionsteknik (en eller flere afkrydsninger) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Radioaktivt sporstof</th> <th style="width: 20%; text-align: center;">Farvestof</th> </tr> </thead> <tbody> <tr> <td>Subareolært</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Peritumoralt</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Subdermalt (over tumor)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Periareolært</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Tumorkavitet</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | Radioaktivt sporstof | Farvestof | Subareolært | <input type="checkbox"/> | <input type="checkbox"/> | Peritumoralt | <input type="checkbox"/> | <input type="checkbox"/> | Subdermalt (over tumor) | <input type="checkbox"/> | <input type="checkbox"/> | Periareolært | <input type="checkbox"/> | <input type="checkbox"/> | Tumorkavitet | <input type="checkbox"/> | <input type="checkbox"/> | Operationsdato: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> </tr> </table> | | | | | | | | | | |
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| Peritumoralt | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Tumorkavitet | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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