5. Primary breast sarcoma or phyllodes tumor
    - The risk of nodal metastasis for breast sarcoma - including angiosarcoma and malignant phyllodes tumor - is negligible.

Indications for sentinel lymph node biopsy (SLNB)

1. cT1mi-3N0 (palpably node-negative) cancer
    - SLNB is indicated for most patients with cN0 breast cancer. This is supported by an extensive body of literature, but with variable use of axillary imaging, so is indicated even if a previously non-palpable, image-detected node was found to contain metastasis.[6,7] (see SLNB #2 below)

2. cT1-2N0 (palpably node-negative) cancer with abnormal axillary imaging and/or a positive lymph node needle biopsy
    - About 70% of patients with a normal axilla on physical examination but abnormal axillary imaging - and about 50% of those with a positive FNA/core needle biopsy – will have 1-2 SLN+ and have the option to avoid ALND.[8] (see SLNB #4 and 5 below)

3. DCIS with a mass, other suspicion of invasion, or requiring mastectomy
    - SLNB is appropriate for DCIS whenever the risk of upstaging to invasive cancer is increased. SLNB is feasible post-mastectomy, but its performance in this setting is unproven.

4. cT1-2N0 (palpably node-negative) cancer with 1-2 SLN+ having BCT with WBRT
    - SLNB without ALND is appropriate for patients undergoing BCT who meet the entry criteria of the IBCSG 23-01 and Z0011 trials and are found to have 1 or 2 positive SLN.[9,10]

5. cT1-2N0 (palpably node-negative) cancer having mastectomy, with 1-3 SLN+ and receiving axillary RT
    - SLNB without ALND is appropriate for patients undergoing mastectomy with 1-3 positive SLN who meet the entry criteria for the AMAROS and OTOASOR trials. The data for 3 SLN+ may be insufficient, in that 95% of AMAROS patients had 1-2 SLN+.[11,12]

6. cN0 (palpably node-negative) cancer post neoadjuvant therapy
    - Upfront image-guided needle biopsy is indicated for any patient with clinical or radiologic suspicion of node metastasis - SLNB should not be done prior to neoadjuvant therapy. SLNB performs well in the post-neoadjuvant setting, and axillary US can suggest treatment response but is not reliable enough to determine the surgical approach. SLNB is suitable for patients who were palpably node-negative, or biopsy-proven node-positive upfront, as long as they are palpably

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