

Evidence Based Guideline

Sentinel Node Biopsy

File Name: sentinel_node_biopsy
Guideline Number: EBG.SUR6630
Origination: 1/2000
Last Review: 4/2005

Active guideline, no longer scheduled for routine literature review.

Description of Procedure or Service

Sentinel node mapping and biopsy is a means of determining the current stage of cancer in patients with melanoma or breast cancer. By selecting a sentinel node and excising and dissecting it, it can be determined if cancerous cells have metastasized, or spread through other lymph nodes and to other areas of the body. The presence of tumor cells in the sentinel node may indicate a need for a radical lymph node dissection. Radical lymph node dissection involves removing the majority of the lymph nodes in the axilla, those under the arms.

The sentinel node is the first node to receive lymphatic drainage from the primary tumor. The patient is injected with vital blue dye. A gamma ray probe identifies the sentinel node. The Sentinel Node Biopsy is performed at the time of the first surgery for breast cancer.

Evidence Based Guideline for Sentinel Node Biopsy

Sentinel node biopsy may be appropriate for the following diagnoses:

- ◆ Melanoma
- ◆ Breast Cancer

Medical Evidence regarding Sentinel Node Biopsy indicates it is not recommended in the following situations:

Sentinel node biopsy is not recommended for all other types of cancer

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 38792, 78195

Medical Term Definitions

Not applicable

Scientific Background and Reference Sources

McMasters KM, Giuliano AE, Ross MI, et al. Sentinel Lymph Node Biopsy for Breast Cancer - Not Yet the Standard of Care. *New England Journal of Medicine* 1998;339(14): 990-995

Nieweg OE, Jansen L, Kroon BB, Technique of lymphatic mapping and sentinel node biopsy for melanoma. *Eur J Surg Oncol* 1998;24(6):520-4

Gennari R, Stoldt HS, Bartolomei M, Zurrada S, et al. Sentinel node localisation: A new prospective in the treatment of nodal melanoma metastases. *Int J oncol* 1999;15(1):25-32

Pendas S, Dauway E, Cox CE, et al. Sentinel node biopsy and cytokeratin staining for the accurate staging of 478 breast cancer patients. *Am Surg* 1999;65(6):500-5;discussion 505-6

8/99 Consultant Review

Medical Policy Advisory Group 12/2/1999

McMasters KM, Tuttle TM, Carlson DJ, et al. Sentinel lymph node biopsy for breast cancer: a suitable alternative to routine axillary dissection in multi-institutional practice when optimal technique is used. *J Clin Oncol* 2000 Jul;18(13):2560-6.

Specialty Matched Consultant Advisory Panel - 6/2001

Specialty Matched Consultant Advisory Panel - 6/2003

Specialty Matched Consultant Advisory Panel - 4/2005

Policy Implementation/Update Information

8/99 Plan Consultant

9/99 Policy developed.

12/99 Approved, Medical Policy Advisory Group

1/00 Policy implemented. Corrected last review date to appropriate date of 1/2000.

2/01 Added new source to Scientific Background and Reference Sources. System coding changes.

6/01 The following statement was added to the description section of the policy, "The Sentinel Node Biopsy is performed at the time of the first surgery for breast cancer." No change in criteria. Format change.

6/03 Specialty Matched Consultant Advisory Panel review. No criteria changes.

Policy: Sentinel Node Biopsy

5/5/05 Specialty Matched Consultant Advisory Panel review 4/14/2005. No changes to criteria. Benefit Application section format updated for consistency. References added. Policy status changed to: "Active policy, no longer scheduled for routine literature review".

10/2/06 Medical Policy changed to Evidence Based Guideline.

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.