INSTRUCTIONS FOR PREPARING ABSTRACT

Read these instructions carefully before typing abstract.
Accepted abstracts will appear in the program exactly as submitted.

1. The entire abstract (title, authors, institution, text, tables and graphs) must fit within a box that's 4.50 inches wide by 6.25 inches deep. Leave no margins within the rectangle, but do not overlap the lines of the box. Single space the entire text of the abstract. ***Authors are encouraged to use the structured abstract format (see sample abstract below).***

2. Typeface or font size must be large enough to be easily read: 10 point size would be the ideal; 8 point size would be the minimum acceptable.

This line is a sample using Arial 8 point. This line is a sample using Arial 10 point. The sample abstract below was done in Microsoft Word using Arial 10 point and Arial 8 point for the authors and institution.

3. CAPITALIZE and center the entire title. Leaving one blank line, follow with the first and last name and degree (MD, PhD, RN, etc.) of each author. The presenting author should be listed first and the senior author listed last. On the next line type the name and location of the institution to be credited.

4. Leaving one blank line, follow with text, tables and graphs.

5. Complete the online abstract form. One completed form must accompany each abstract submitted. No abstract will be considered without a completed form.

6. The abstract should be submitted in Word format, to fit 4.50 x 6.25 inches, upload files in online form by **September 6, 2019**.

Axillary Lymph Node Metastasis Breast Carcinoma and Technetium -99m Sestamibi Scintimammography

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Introduction: Technetium-99m sestamibi scintimammography (SSM) has been used effectively for the diagnosis of breast carcinoma with a sensitivity of 92.2% and specificity of 89.2%.
Objective: To determine the value of SSM for the detection of axillary lymph node metastasis.
Participants: Thirty-one women with known breast carcinoma. SSM was performed following IV injection with 20 mCi of Tc-99m sestamibi. Five and ten minutes post injection a lateral prone image of the breast as well as an anterior view of both breasts with the arms elevated were obtained for the evaluation of the axilla. All women had axillary node dissection. All SSM scans were interpreted by two nuclear medicine physicians blind to clinical and histological findings. Focal areas of increased uptake in the axilla were considered positive.

Results:

Axillary Contents	Histology Benign	Histology Malignant	Total
SSM Benign	9	5	14
SSM Malignant	2	15	17
Total	11	20	31

Sensitivity = 75%, Specificity = 82%
Positive predictive value = 88%, Negative predictive value = 64%

Conclusion: This data suggests that SSM might be an effective test to evaluate the axillary region in patients with breast carcinoma. There is a critical need to develop a dedicated nuclear medicine detector to improve SSM in the detection of axillary metastasis.

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