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Research Article

**LOCALIZATION OF INTRADUCTAL MASS THROUGH THE  
OSTIUM OF DUCT USING WIRE GUIDED DUCTOGRAPHY  
TECHNIQUE**<sup>1</sup>Dr. Muhammad Salman Ashraf, <sup>2</sup>Dr. Uzaira Khaliq, <sup>3</sup>Aurang Zeb Ahmad<sup>1</sup>Mayo Hospital Lahore<sup>2</sup>Allied Hospital, Faisalabad<sup>3</sup>Children Hospital Faisalabad**Abstract:**

**Purpose:** The purpose of the study location of industrial mass (Papilloma). The mass is located prior to surgery.

**Material:** Plastic 26G to 20G/V cannulas Disposable syringe heaving 2ml non-ionic contrast. Guide wire 10-15 cm length of 2/3-0 Prolene / Surgipro Light of high intensity and magnified glass. Kopans breast lesion localization hook wire. Prolene/Surgipro.

**Methods:** By using antiseptic lotion, nipple is cleaned. Light of high intensity is regulated and a patient is placed in the sitting position or in lying position. With slight per areolar force, discharged is dragged. Discharged could be brought about by the patients him selves. Magnified glass is used for the observance if the opening with discharge is not obvious. Loop can also be used for this purpose. In the duct orifice, wire is placed steadily. Wire should be preceded smoothly into the duct. Guide wire is separated after inauguration of 26G 11V plastic cannula coaxially over the guide wire. Then 0.2-0.4 ml contrast is injected slowly and syringe is withdrawer. After this, stopper is placed. Tape is applied on the union of cannula and stopper for protection. Crinocauda magnification is done for view of breast. The cannula with larger length 22/20G is selected and the distance of lesion from the ostium is maintained, cannula is passed over guide wire slowly. The cannula with length 26G is rejected. From the nipple 2cm wire is removed. Guide wire replaced the hook wire and place of hook is established by mammographic film. After this, patients are moved towards the operation theater.

**Results:** The results indicate that in six patients, localization of hook has been done successfully.

**Conclusion:** This procedure of localization of intraductal mass is innovative. Surgeon is able to do microductetomy with less cosmetic effect to breast by using this method.

Localization of intraductal mass through the ostium of the duct using wire guided Ductography technique.

**Key Words:** Localization, Intraductal Mass, Ostium Of Duct, Wire Guided Ductography Technique.

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**INTRODUCTION:**

For the isolation of intraductal mass, a new method is developed by Aslam et al 2012. In this procedure, wire guided ductography is used and through the ostium of duct, intraductal mass is isolated. For indicating the pathology that's led to nipple discharge, ductography is a radiological method. Diagnosis can be done through it. It is also helpful in painting the actual location in the duct for abnormality like duct ectasia [1,2,3]. For this study, six patients were choosd. The selection is done by using wire guiding technique for ductography. Prior to surgery, by means of duct ostium, Kopar, a localization hook wire is inserted at the intraductal injury.

Some surgeons are of view that management is not altered by DG and due to this reason, they do not own DG [4] they believed that discharged of nipple is complicated and treatment of surgical duct exploration is optimal. Surgical pulling of larger part of the breast has been changed to microsurgery. Now smaller part of breast is pulled up, for the last decades. This change is due to the reason that international radiology method is proceeded.

Patients is made ready for surgery after indication of intraductal tumor. For the removal of tumor, methylene blue injection [5] is used by most of the centers. In order to have the clear view of tumor, methylene blue is injected into the discharging duct. After this, circumareolar scarification was done. Because of blue color ducts and lobules are highlight and they are cut down easily. After small circumareolar cut surgeon identify the hook by using our procedure and then, it is removed.

**MATERIALS:**

The material used for this procedure are as under:  
Hard plastic guide wire length 10-15 cms.  
Prolene/Surgipro 2-00/3-0. In the operation theaters, wire quickly available can be used as guide wire.

- Kopans breast lesion localization hook wire
- Magnified glass and light of high intensity,
- Plastic 26G to 20G intravenous cannulas used for cannulation as well as for placement of hook wire.
- Disposable syringe heaving 2ml non-ionic contrast.

**METHODS:**

When the nipple is being discharged, the method is carried out [3]. Nipples are released by using anti-septic lotion. Light of high intensity is arranged and patients is made ready in sitting or lying position. With slight priareolar force, discharge is dragged.

Discharged could be brought about by the patient himself. Mostly patients are aware of specific point trigger point [1,2,3,5] in order to bring the discharge. The opening of discharging duct may be moderately erythematous [4]. When the ostium of the duct with discharged compared to the adjacent normal duct onifice is observed. Magnified glass or loop is used for the clear view of opening with discharge. Wire is placed into the opening of duct gradually. It should pass smoothly and don not cause any pain. If pain is felt by the patients, presence of wire is in the duct is ensured. Wire could be inserted deeply into the duct, by pulling the nipple and spinning the wire. Over the guide wire, 26G 1/V cannula is inserted coaxially.

The cannulation of duct with pathology is done. This is ensured by noticing the discharge coming up in the hub of the cannula. Syringe is separated after injecting gradually 0.2-0.4 ml contrast and stopper is used. Tape is used for the protection of cannula stopper association. Craniocaudally magnification is done for view of breast. The image is observed and through the cannula, guide wire is inserted again. Craniocaudally view is taken again. In the contrast filled duct, guide wire will observe as filling disorder. The association of wire, tip of cannula and tumor is examined. The position of cannula in the wire is changed if the guide wire and cannula is connecting at the exact branch of duct in which tumor is present. Guide wire replaced the hook wire and placed of hook is established by mammo-graphic film. On the breast protected in place with the striking tape, place the plastic drinking cup. The cup should be disposable. From the nipple, 2cm wire is removed. Then, patients are ready to move to the operation theater.

**RESULTS:**

The result indicates that in patients, this technique has been carried out. 30 to 56 year was the age bracket for the patients. This procedure is carried out between the years 2007-2011. Another technique is methylene blue injection. In this technique lobules had to be separated. As compared to methylene blue injection, this technique is more accurate and exact in intraductal mass localization for the surgeon. By using this procedure, microsurgery is done with optional separation of duct in which mass is present. The cases in which lemurs are less than 5cm from the nipple with equitable straight path of the duct, the performance of this method is better. The choice of patients is significant for affluent localization with hook.

**CONCLUSION, DISCUSSION:**

By using wire guided ductography method, this procedure identification is innovative for of intraductal mass. Surgeon is able to do microductectomy with less cosmetic effect to breast by using this method. Moreover, surgeon is relaxed in performing the operation of identification the injuries having hook around it.

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