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Oncoplastic surgery allows extensive resections for conservative treatment of breast carcinoma

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Summary Background Data: The number of breast cancer patients treated with breast conservation is expanding. However, when proposing breast conserving therapy, one should be sure to leave a normal appearing breast, as secondary reconstruction of breast deformities is difficult: it requires further operations and often leads to disappointing results. The objectives for conservative breast cancer surgery are thus to develop surgical techniques that allow wide resections with free histologic margins, but do not distort the breast.

However, in patients with large, ill-defined or poorly situated tumours, cosmetic results after conservative surgery can be poor and clear resection margins difficult to obtain. Oncoplastic surgery is a novel surgical approach, which integrates plastic surgery techniques at the time of the initial lumpectomy. Initially this approach was developed to allow wide breast excisions and prevent breast deformities. Oncoplastic surgery has furthermore allowed us to extend the indications of breast conserving surgery to tumours that would otherwise be treated by mastectomy.

Methods: All Oncoplastic techniques are based upon plastic surgery techniques that are used to immediately reshape the breast at the time of the initial conservative surgery. They can be unilateral or bilateral, as a contralateral symmetrization is often necessary to obtain breast symmetry. When indicated, this symmetrization is performed during the same initial operation as the lumpectomy. Over the years, we have developed a wide range of techniques, to be able to answer most clinical situations, depending on the breast volume and the tumour location.

We present a prospective study of 300 patients who were operated on for breast carcinoma between July 1985 and December 2002. All patients had a wide tumor excision, with a remodelling mammoplasty and immediate contralateral symmetrization. The procedure was proposed for patients in whom conservative treatment was possible on oncologic grounds but where a standard lumpectomy would have led to a poor cosmetic result. Standard institutional treatment protocols were followed. Depending upon ongoing protocols at the time of treatment, patients were proposed pre-operative chemotherapy to downsize their tumours.

Results: In a series of over 300 patients, mean tumor size was 32 mm (range 10–110). The mean weight of the lumpectomy specimen was 220 g, as compared with 30 g for a standard lumpectomy, showing the extent of resection one can perform by performing these oncoplastic techniques. Postoperative treatments (chemotherapy, hormonal treatment or radiotherapy) were not modified because of the surgical treatment, and all patients received post-operative radiotherapy. Results showed actuarial 5-year local recurrence rate of 8% (1.8–16.9), overall survival rate of 93.7% (91–100) and metastasis free survival rate of 88.4% (72.5–93.2). Cosmesis was favourable in 82% of cases.

Conclusions: The use of oncoplastic techniques and concomitant symmetrization of the contralateral breast allows extensive resections for conservative treatment of breast carcinoma and results in a favourable oncologic and aesthetic outcome. The indications for oncoplastic surgery are patients for which the ratio between tumor volume and breast volume is such that a standard excision is not technically feasible, whilst conservative treatment is safe by oncologic grounds. This approach is useful in extending the indications for conservative therapy. It is fully compatible with preoperative chemotherapy and postoperative radiotherapy and chemotherapy, and is now part of our multidisciplinary approach for breast cancer treatment.

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Follow-up after breast reconstruction

Abstract not received.

247 Proffered Paper Oral

Assessment of patients' satisfaction with cosmetic results, impact on body image and sexuality after mastectomy and immediate plastic surgery with nipple preservation

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Introduction: The psychological impact of mastectomy and breast reconstruction has now been well documented, however the contribution of nipple removal and successive addition with tattoo procedure or its preservation has not been studied.

In a surgical trial at Milan's European Institute of Oncology, women with invasive breast cancer (CI) or Ductal Carcinoma *in situ* (DCIS) undergoing mastectomy were offered to spare the nipple (NAC) by performing intra-operative radiation therapy (IORT). The psychological and body image impact of breast loss with or without nipple preservation was assessed along with its impact on sexuality and the fear of recurrence.

The aim of the study was to determine whether NAC sparing in mastectomy is important or not in body image perception, sexuality and in patients' satisfaction with cosmetic results.

Methods: Women who had a mastectomy with NAC sparing and immediate breast reconstruction and women who had a mastectomy with immediate breast reconstruction and successive nipple reconstruction with tattoo, were evaluated from September 2004, about four months and one year after the surgery (in the nipple sparing group) and one year after the nipple reconstruction in the other group.

We administered the Psychological Inventory Distress (G Morasso), the LASA Scale (Coates A), the Body Image scale (P Hopwood) and a new specific questionnaire tailored at assessing patients' satisfaction with cosmetic results, NAC preserving surgery results and possible impact on sexuality (F Didier, not published). We also collected socio-demographic data, complications after surgery, and post-surgery oncology treatments.

Results: 70% of women responded to the study.

Preliminary results based on patients who underwent a nipple sparing mastectomy recruited up to the end of November 2005 will be presented.

225 women were evaluated, 139 patients completed the questionnaires 4 months after surgery and 86 patients 12 months after surgery.

Preliminary results indicated a very high level of satisfaction with NAC preservation. The majority of these women (80%) expressed the feeling that the new technique helped them feel less mutilated.

Conclusion: The study is still ongoing. We still need to compare the two groups of women to determine whether NAC sparing in mastectomy is important or not for women.

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Thursday, 23 March 2006 14:15–16:00

EUROPA DONNA SESSION

Breast cancer under 40

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What we need to know

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The data concerning adjuvant endocrine therapies for young women are incomplete and thus we often have to make treatment decisions, for example, whether to use goserelin (g) in addition to tamoxifen (t) or chemotherapy in addition to endocrine therapy from indirect data or subgroup analysis. However, from the overview, it is clear that tamoxifen for 5 years or ovarian ablation or suppression are effective and each modality alone gives similar results with respect to disease free and overall survival [1]. The ZIPP trial demonstrated goserelin (g) + tamoxifen (t) was better than g alone [2]. Chemotherapy + tamoxifen is superior to tamoxifen alone in the Overview but in general ovarian suppression adds little to chemotherapy probably because of the endocrine effect of chemotherapy-induced ovarian ablation. However, the situation is clearer in women under 40 where chemotherapy produces little ovarian suppression. In the intergroup 0101 trial [3], for example, the 9 year disease free survival in women <40 for CAF chemotherapy was 48%, for CAF + goserelin (g) was 55% and for CAF + g + t was 64% suggesting that g + t are additive (and add to chemotherapy) as is seen in advanced disease [4].

In the IBCSG trial VIII it was shown that chemotherapy adds to goserelin vs goserelin alone but only in women under 40. Several studies show that, in patients with ER+ve tumours, t alone or t + g is equivalent to chemotherapy (anthracycline and non-anthracycline based) [5]. Despite the data outlined above it is not clear whether the treatments combined are better than either alone. Analysis of the 21 gene array in NSABP trials and of all of the SWOG data over the years suggest that chemotherapy might add little to endocrine therapy in response ER+ve tumours. Thus, there are still outstanding questions from older trials and also where the aromatase inhibitors fit. These questions should be answered by new trials such as SOFT, TEXT, PERCHE which will be described.

Key papers on this topic have been published by Dellapasqua et al. [6], Jakesz et al. [7], Pritchard [8], Thewes et al. [9], Kaufmann et al. [10], Aebi