ciated with increased local recurrence rates. Only 30–40% of re-excisions, however, contain further tumour. The aim of this paper was to determine if there are any histological factors which can predict a subgroup of patients with positive surgical margins who do not require re-excisions.

This is a retrospective review of 112 patients requiring re-excision for positive margins, defined as <1 mm margin for invasive cancer or ductal carcinoma in situ (DCIS). Seventy-two patients (64%) had negative re-excisions while 40 (36%) had residual disease on re-excision. The mean age, side of the cancer, number of patients with family history of breast cancer and palpability of the cancers were similar between the 2 groups. There was a higher proportion of patients with lobular subtype and node positive disease in the positive re-excision group as compared to the negative re-excision group.

In this study, only 35% of patients undergoing re-excisions for positive margins had further disease. While there was a higher proportion of patients with lobular subtype in the positive re-excisions group, this was not statistically significant ($p = 0.09$). There was a statistically significant number of patients with node positive disease in the positive re-excisions group ($p = 0.002$). We did not, however, identify a particular factor which would predict for a subgroup of patients who would have negative re-excisions. All positive margins should therefore be re-excised.

O-46. Relationship between presence of lobular carcinoma in situ and risk of local recurrence in patients with primary breast cancer treated with breast conserving surgery and radiotherapy

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In an otherwise benign biopsy, lobular carcinoma in situ (LCIS) has been associated with an increased risk of developing breast carcinoma. However, the association between LCIS and risk of local recurrence (LR) in patients with Breast conserving surgery (BCS) and radiotherapy (RT) is debated.

Of 2800 cases of invasive breast cancer diagnosed and treated in Nottingham between 1996 and 2003, 1.8% ($n = 53$) were identified that had been treated by BCS and RT and had surrounding LCIS. No attempt was made for complete excision of LCIS at the margins in these cases but invasive disease and any surrounding DCIS was at least 5mm clear at the margins. A control cohort ($n = 509$) was selected from the same dataset, which were matched for size, VI and NPI.

Median age was 63.8 years with a median follow up of 32 months. Significant associations were seen only with ER positive disease ($p < 0.005$) and lobular type ($p < 0.005$). There was no relationship with the presence of surrounding LCIS and grade, size or vascular invasion (VI). Local recurrence rate in the LCIS group was 1.9% vs 1.4% in the controls ($p = 0.55$). There were no events of contralateral disease or distant metastasis in the series to date.

BCS and RT is an appropriate form of treatment in tumours with surrounding LCIS. Its presence does not appear to significantly increase the risk of LR.

O-47. Does mastectomy for involved margins confer advantage over further local excision to clear margins following conservative surgery in early breast cancer?

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This study compares early results (36/12) after mastectomy (Group A, $n = 67$) with those achieved after re-excision (Group B, $n = 38$) following incomplete wide local excision for operable breast cancer.

Method: Between 1 January 1996 and December 2001, 430 consecutive patients received wide local excision (WLE) for operable invasive breast cancer. All patients had lymph node sampling or clearance at the initial procedure and patients with involved margins either underwent re-excision (Re-ex) or mastectomy (Mx). Patients with positive nodes received axillary radiotherapy or clearance. Systemic adjuvant treatment and irradiation to the conserved breast or mastectomy flap was prescribed according to local protocols. Local and Regional recurrence and distant metastasis at 36/12 were compared between Group A and Group B.

Results:

Minimum follow up (FU) = 36/12 and median follow up = 6 years

Final 0peration	WLE	Re-ex	Mx
Total number of patients	325	38	67
Patients lost for Follow up	15	2	3
Patients deceased during study period	15	2	6
LR 36/12	3	1	1
No LR 36/12 CHI/SQ: 0.99 p = N/S	293	33	57
RR 36/12	8	1	4
No RR 36/12 CHI/SQ: 2.67 p = N/S	290	33	54
DM 36/12	9	1	4
No DM 36/12 CHI/SQ: 2.52 p = N/S	291	34	56

LR = Local Recurrence RR = Regional recurrence DM = Distant Metastasis. All figures relate to absolute numbers at 36/12 follow up.

Conclusion: There is no early advantage of completion mastectomy over re-excision after inadequate wide local excision for primary breast cancer.

O-48. Timing of radiotherapy and survival in breast-conserving therapy

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Purpose: To estimate the effect of delay in timing of radiotherapy in breast-conserving therapy (BCT) on local recurrence and distant metastasis.

Methods and materials: We analysed our prospective cohort of 1391 BCT, stage I or II, node-negative breast cancer patients without adjuvant systemic therapy. Seven hundred and thirty patients started the radiotherapy in the same month or one month after lumpectomy <2 months), 546 in the second month (=2 month), and 115 started radiotherapy in the third month (=3 month). Median follow-UR was 88 months.

Results: There was no difference in local relapse-free survival (LRFS) between the three groups, the 7-year LRFS rates were respectively, 95.6% for <2 months, versus 97.0% for =2 months, versus 97.7% for =3 months. The 7-year distant metastasis-free survival (DMFS) was 85.1% for <2 months,