

following breast conservation for invasive disease with involved margins is not significant.

Whilst there is likely to be under reporting of local recurrence with reliance on local centres sending data. This system of reporting seems robust enough to provide large scale data until the arrival of the long awaited single patient record.

#### O-42. Comparison of local recurrence between screen detected and symptomatic breast cancer

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Screen detected breast cancers in general have a lower recurrence rate than symptomatic cancers but little data is available on the local recurrence rate for both screened and symptomatic cancers.

**Aims:** To compare the local recurrence rate between screen detected breast cancer and symptomatic breast cancer in the same age group (50–65 years) in one breast unit between 1990 and 1998; 962 SDBC and 645 symptomatic women were treated and local recurrence rate compared.

**Results:** Significantly lower local recurrence rate was seen in the screen detected breast cancer group compared to symptomatic group. Using an index based on tumour grade scored (1, 2 or 3), size (<15 mm = 1, 15–25 mm = 2, >25 mm = 3) and node status (negative = 1, <4 nodes positive = 2, >4 nodes positive = 3) was formulated. Scores of each parameter were added together producing a range from 3 to 9. Local recurrence rate was significantly lower in all screen detected breast cancer groups except for those at the highest risk of recurrence (score 9) despite significantly less radiotherapy being used for screen detected breast cancers in terms of mastectomy flap irradiation.

Table 1

| Index Score | n   | SDBC Recurrence |         | n   | Symptomatic Recurrence |         | P         |
|-------------|-----|-----------------|---------|-----|------------------------|---------|-----------|
|             |     | local           | Distant |     | Local                  | Distant |           |
| 3           | 166 | 0%              | 0%      | 80  | 1.3%                   | 4.1%    | P < 0.001 |
| 4           | 292 | 1.4%            | 2.2%    | 156 | 5.1%                   | 7.4%    | P < 0.01  |
| 5           | 250 | 2.4%            | 4.4%    | 155 | 6.5%                   | 16.8%   | P < 0.01  |
| 6           | 156 | 4.0%            | 6.6%    | 127 | 4.7%                   | 19.8%   | P < 0.03  |
| 7           | 45  | 11.1%           | 26.3%   | 74  | 18.9%                  | 27.6%   | P < 0.001 |
| 8           | 38  | 28.9%           | 33.9%   | 45  | 42.2%                  | 44%     | P < 0.001 |
| 9           | 15  | 66%             | 42.6%   | 8   | 37.5%                  | 63.5%   | NS        |

**Conclusion:** Screen detected breast cancers are at low risk of local recurrence.

#### O-43. Local recurrence after breast cancer screening

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Prognosis overall in screen detected cases is better than in those presenting symptomatically (87% vs. 75% 10 year case survival).

This paper compares local recurrence (LR) rates in screen detected and symptomatic women, aged 50–65, in consecutive cases treated at Nottingham City Hospital in 1990–99.

Table 1

|                     | Screen Detected |      | Symptomatic |       |
|---------------------|-----------------|------|-------------|-------|
|                     | n               | LR   | n           | LR    |
| Wide Local Excision | 320             | 7.8% | 228         | 10.1% |
| Mastectomy          | 221             | 4.1% | 311         | 6.4%  |
| Total               | 541             | 6.3% | 539         | 8.0%  |

LR rates are only a little lower in screen detected cases than in symptomatic cases.

The better prognosis of screen detected cases is due to their better prognostic features (Grade, Lymph Node Stage and Size). Different factors are more important for LR, (Grade, Lymph Node Stage, Size, completeness of excision and Lymphovascular Invasion).

#### O-44. The significance of the in situ component of a positive margin in breast-conserving therapy in breast cancer

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**Purpose:** to identify the importance of a positive margin for carcinoma in situ (CIS) versus invasive carcinoma in breast cancer patients treated with breast-conserving therapy (BCT).

**Methods and Materials:** A total of 2091 BCT were analysed. The margins were positive for invasive carcinoma in 8.4% of BCT and 6.1% for CIS. The median follow-up was 80 months. Because of a statistical interaction with age, all analyses were done according to age category.

**Results:** The 10-year local recurrence-free survival (LRFS) for women ≤40 year for negative margins vs. positive margins for invasive carcinoma vs. positive margin for CIS was 83.8% vs. 34.6% vs. 53.5%. In multivariate Cox-regression analyses only a positive margin for invasive carcinoma was significant. Status for invasive carcinoma for women ≤40 year was also a significant predictor for distant metastasis-free survival (DMFS), disease-free survival (DFS), and disease-specific survival (DSS).

The 10-year LRFS for women >40 year for negative margins vs. positive margins for invasive carcinoma vs. positive margin for CIS was 94.9% vs. 94.0% vs. 79.4%. In multivariate Cox-regression analyses a positive margin status for CIS was significant.

Status for CIS was also associated with a reduced DFS for women >40 year.

**Conclusion:** Margin involvement for CIS shows to be an independent risk factor for LRFS and DFS in breast cancer patients, >40 year. For women ≤40 year a positive margin for invasive carcinoma was an independent risk factor for LRFS, DMFS, DFS and DSS.

#### O-45. Positive lumpectomy margins: is re-excision always necessary?

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Involved surgical margins of lumpectomy specimens are asso-