

### O-58. More breast conserving surgery (BCS) performed with saline instillation and fewer local relapses

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BCS is safe, with no increase in mortality in spite of 6–10% local relapses after 10 years, but the relapse rate must be kept low. What can be done in order to raise the number of BCS without more relapses, more re-resections and bad cosmetic results? During the last 4 years we have focused on the following technical details and compared with results the years before:

1. “The saline instillation method”, 2. Always dissection from the subcutaneous fascia to the pectoralis major fascia, full thickness. These details increase the local “radicality”.

Ad 1. Saline is instilled into the wound cavity, and larger molecules leaking into the cavity keeps most of the volume intact through long time, new tissue is formed, and scarring and deformity is reduced.

Ad 2. Full thickness specimen gives standardized conditions for the pathologist, and only the side margins have to be considered. Our definition of radicality is >3mm in invasive cancer and >5mm in DCIS. BCS was done in 70% in 2000, in 82% in 2003. These numbers include DCIS cases and all ages. Half of the cancers were detected clinically and the other half by screening. After the introduction of the saline instillation method the radicality index i.e. weight of the specimen divided by the tumour diameter, was increased 140%. 446 pts have been operated during this span of time, all have been followed up by our department and only two relapses are detected, i.e. 0.4% after mean follow up of two years. In many materials the relapse rate has been shown to be constant year by year, and our rate seems to give 2–3% after 10 years in a population of 82% BCS operations performed.

“The saline instillation method” seems to make this possible raising the “radicality” and the cosmetic result at the same time.

### O-59. Critical appraisal of the nomogram for predicting non-sentinel lymph node metastasis

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**Introduction:** The standard of care for breast cancer patients with sentinel lymph node (SLN) metastasis is to perform complete axillary lymph node dissection (CALND). However, the value of CALND can be questioned in patients judged to have low risk of further axillary lymph node disease. A web-based nomogram has been developed (Memorial Sloan Kettering Cancer Center) to estimate the risk of non-SLN disease if the SLN shows metastasis. The nomogram utilises information such as tumour grade, type and size, the presence of lympho-vascular invasion, number of SLN metastases and their method of detection. This study aims to test the validity of the nomogram.

**Methods:** The nomogram was applied to 89 patients with SLN metastasis who subsequently underwent CALND. The nomogram-derived risk was compared with the definitive histopathological status of the non-SLNs and the correlation coefficient calculated. To assess how the nomogram could be applied clinically, we investigated whether a threshold value

of % risk of non-SLN metastasis from the nomogram could influence the decision to proceed to CALND.

**Results:** The correlation coefficient was 0.47. A threshold value of 10% from the nomogram generated a false negative prediction rate (understaging of the axilla) of 15% and a false positive prediction rate (overstaging of the axilla) of 50% in our series.

**Conclusion:** The correlation coefficient of 0.47 contrasts with that of the developers of the nomogram (0.97). Additional factors which may be of importance are currently being investigated.

### O-60. ONCOPOOL – a European dataset in 16893 cases of breast cancer

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The SEER data (Henson 1991 [1], Carter 1989 [2]) has long been regarded as providing the best information on the characteristics of breast cancers at diagnosis and on outcomes.

Survival has improved greatly since the 1980's across the prognostic range. ONCOPOOL (FP 5 EC Grant) is a dataset from 11 European units, with QA and long term follow up.

Consecutive cases ( $n = 16500$ ) in years between 1990 & 1999 were entered. This has given up to date information on treatments and of Pathology and biological factors at diagnosis and the effect of these on recurrence and survival (Tables 1 & 2).

Table 1. Percentages on pathology

Tumour Size (cm)				
0-1 cm	1.01-2 cm	2.01-3 cm	3.01-4 cm	4.01-5 cm
26	49	19	5	2
Lymph Node Status				
Negative	Positive <4		Positive 4+	
66	24		10	
Grade				
I	II		III	
29	42		29	

Table 2. Survival according to Nottingham Prognostic Index (NPI)

NPI Group	% in group	% 10 year survival Actuarial
Excellent	20	95.6
Good	27	91.4
Moderate I	26	81.7
Moderate II	16	72.7
Poor	11	50.8

A great deal more data is being analysed, ONCOPOOL should now be regarded as the key dataset.

**References:** [1] Relationship among outcome, stage of disease and histologic grade for 22616 cases of breast cancer. *Cancer*: (1991) November 15, Vol. 68, 2142–2149

[2] Relation of tumour size, lymph node status and survival in 24740 breast cancer cases. *Cancer*: (1989) January 1, Vol 63, 181–187.