O-109. Therapeutic mammaplasty – approach to planning and techniques

McCulley SJ, Macmillan RD. *Nottingham City Hospital*

Therapeutic mammaplasty is the use of reduction mammaplasty techniques to treat selected breast tumours. It enables an expanded role of breast conserving surgery in cases requiring large percentage breast volume excisions, excisions in sensitive areas of the breast (central, inferior and medial) and patients with marked macromastia. Most commonly described is the use of a Wise pattern mammaplasty to remove tumours that lie within the expected mammaplasty excision. However, mammaplasty techniques can be safely adapted to treat patients with cancers in all areas of the breast. Our approach to selection and planning surgery has developed from experience with our first 50 cases. This presentation presents the technical details our approach. Techniques vary depending upon the tumour position. Breast cancers that lie within the normal excision site of a recognised mammaplasty method (scenario A) will be treated by that method without modification. Those lying beyond the expected excision sites (scenario B) require a range of techniques and modifications. Three decisions are needed for planning in scenario B; the skin incision, the nipple-aereola complex (NAC) pedicle orientation and finally the method of filling the cancer defect. The latter can be achieved by either extending the nipple pedicle or by creating a secondary pedicle within the breast dissection. Either method will move tissue that is normally excised into the cancer defect. The pedicle orientation can be from any direction.

For central tumours either a form of wedge excision or an inferior advancement pedicle is usually used to both fill the defect and recreate the nipple.

These simple principles allow a huge range of options to be employed to treat most breast tumours suitable for breast conservation. The use of therapeutic mammaplasty becomes very valuable in large percentage excisions when a poor cosmetic outcome is expected.

O-110. The growth rate of breast cancers in the observed phase according to grade

Burrell H, Blamey RW, Pinder SE. *Nottingham City Hospital*

76 breast cancers were studied. These were interval cases, which were retrospectively judged to have been false negatives at screening.

Lesions had to be measurable at both false negative and final diagnosis as a soft tissue abnormality. Cases with calcification as the main abnormality were excluded. The measurement taken was the maximum diameter on mammogram in millimetres. There was a good correlation between the size at final diagnosis and the histological size.

The overall result is given in Table 1.

Table 1

	Number	Average growth rate mm/yr
Grade 1	10	5.72
Grade 2	36	6.44
Grade 3	30	9.64

Table 2

Grade	Months
I	19.5
II	18.3
III	16.0

Taking the diameter at false negative time into account, the mean diameter doubling times were as given in Table 2.

O-111. Switching to anastrozole (ANA) vs continued Tamoxifen (TAM) treatment of early breast cancer (EBC). Updated results of the Italian Tamoxifen Anastrozole (ITA) trial

Boccardo F, Rubagotti A, Guglilmini P, Porpiglia M, Mesiti M, Rinaldini M, Paldini G, Distante V, Franchi R, Soto Para H, Buzzi F, Massidda B, Amadori D, Sismondi P, Cruciani G, Farris A and other ITA trialists. *National Cancer Research Institute & University of Genoa, Italy*

Background: Switching to ANA after 2–3 years of TAM is well tolerated and significantly improves event-free (EFS) and progression-free survival (PFS) of postmenopausal ebc (Breast Cancer Res Treat 82, 2003). Here we report on an additional analysis including 87 events and 26 deaths at a median follow-up time of 52 mos (1–80 mos).

Methods: This was an open phase III trial comparing TAM vs ANA following 2–3 years of treatment with TAM (total duration of endocrine therapy: 5 yrs) and including 448 node+ve ER+ve patients. PFS was the primary end point. EFS, OS and safety were secondary end points.

Results: The Hazard Ratios (ANA vs TAM) for EFS, PFS, local (1) PFS and distant (d)PFS are summarized in the table (Hazards of previous analysis are reported for comparison).

	Median follow-up time: 36 mos		Median follow-up time: 52 mos	
	HR (95% CIs)	$p =$	HR (95% CIs)	$p =$
EFS	0.35 (0.20–0.63)	0.0002	0.42 (0.26–0.66)	0.0001
PFS	0.35 (0.18–0.68)	0.001	0.43 (0.25–0.73)	0.001
1PFS	0.15 (0.03–0.65)	0.003	0.13 (0.03–0.59)	0.002
dPFS	0.49 (0.22–1.05)	0.06	0.57 (0.32–1.02)	0.06

17 women continued on TAM died as compared to 9 of those switched to ANA (HR: 0.52; 95% CI 0.23–1.17; $p = 0.1$). 40% and 46% of women developed at least one AE in the two groups respectively ($p = 0.2$).

Conclusions: Safety and clinical benefits of switching to ANA following 2 or 3 years of TAM are confirmed by this updated analysis.

O-112. Aromatase inhibitors (AI) versus Tamoxifen for ER-positive breast cancer – a meta-analysis

Gray R, Hills R, Shah L, Stowe R. *University of Birmingham Clinical Trials Unit*

Background: Tamoxifen treatment of ER-positive breast cancers for 5 years improves 15-year survival by almost 10 percent. AI therapy, instead of, or after the completion of standard ta-