

### O-17. Risk reducing mastectomy (RRM): high incidence of occult breast cancers

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RRM is an aggressive but controversial strategy for breast cancer risk reduction. We conducted a retrospective study of all women with or without a previous history of breast cancer who underwent a RRM between 1997 and 2004. A comprehensive genetic risk assessment was performed and patients were categorised into near population, moderate or high risk of developing breast cancer. Reconstructive data and pathological reports were also reviewed.

There were 34 patients with a median age of 42 years (range 29–55 years). Two groups were identified: (A) patients with no history of breast cancer and had a bilateral RRM ( $n = 12$ ) and (B) patients with a previous history of breast cancer and had a contralateral RRM ( $n = 22$ ). In group A, pathological review revealed that 17% of patients had positive pathology: one had a small grade 1 tumour and one had lobular carcinoma in situ. In group B, 27% had positive pathology: 13% had an occult malignancy and 17% had high risk pathology. Of those patients with positive pathology, 86% were calculated by the geneticist to be at moderate or high risk of developing breast cancer. None of the lesions were detected by mammography prior to surgery. Median follow-up was 23 months (1 year to 7 years) with no incidence of breast cancer.

Patients that underwent a contralateral RRM and were calculated by the geneticist as high or moderate risk subsequently were shown to have a 32% incidence of having a malignant or high-risk pathological lesion. Surveillance did not detect these lesions and our study would support the use of contralateral RRM in this carefully selected group of patients.

### O-18. Risk reducing mastectomy: a survey of current practice in the UK

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**Aim:** Prophylactic mastectomy is an option for women who are at increased risk of developing breast cancer. The aim of this study was to determine the current practice of risk reducing mastectomy (RRM) in the UK.

**Methods:** A questionnaire was sent to all the practicing breast surgeons in the UK through the BASO group. The indications, risk assessment model, role of genetic testing, psychological counselling and availability of breast reconstruction were assessed.

**Results:** 81% performed RRM; 76.5% general surgeons with interest in breast, 20.5% breast surgeons and 3.5% plastic surgeons. Proportion of RRM performed as compared to number of cancers was 0.33–16.66% (median: 2.0%). 66.5% perform risk estimation: 33.3% used Gail, 4.9% Claus, 14.7% used both and 13.7% used other methods.

Recommendations for RRM included: hereditary breast cancer (99.3%), significant family history (58.6%) and past/present contra-lateral breast cancer (61.9%). The procedure was not supported in patients who had atypical hyperplasia, in-situ can-

cers and ipsi-lateral multi-focal cancers. 89.6% discussed the role of RRM in the MDT before offering the procedure. 96.49% offer immediate or delayed reconstruction following RRM. Only 42.9% offered psychiatrist/psychologist counselling.

**Conclusions:** RRM is only appropriate for a small proportion of women with a family history of breast cancer. There is no consistent practice in offering RRM in UK and standardisation is required.

### O-19. Systemic cavity shaves reduces positive margins and re-excision rates in breast conserving surgery

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The role of cavity shaves in reducing re-excision rates has not been determined. This study aimed to compare rates of involved margins and re-excision following cavity shaves based on either intraoperative radiology or systematic cavity shaves.

Data was recorded prospectively from 1999 to 2004 for 217 patients undergoing wide local excision of biopsy proven breast cancer. From 1999 to 2001, cavity shaves were only performed when intraoperative radiological margins appeared close. An audit of the first 106 cases (1999–2001) showed the superior/inferior resection margins accounted for 90% of positive margins. Consequently, systematic superior and inferior cavity shaves (SSICS) were performed on the remaining 111 cases. Positive margins and re-excision rates were then compared between groups.

The median weight of excised tissue was less in the SSICS group: 82.8 grams, IQR 57.1–110.3 versus 100.5 grams, IQR 75–147.6,  $p = 0.001$ . The introduction of SSICS was associated with a 68% reduction of involved margins (18/106 to 8/111), relative risk (RR) 0.17, 95% confidence interval (CI) 0.08–0.48,  $p = 0.001$ . Multivariate analysis showed SSICS also reduced re-excision rates (15 versus 8 cases), RR 0.26, 95% CI 0.09–0.74,  $p = 0.012$ .

Positive margins and re-excision rates are reduced by Systematic cavity shaves. This approach has additional cosmetic benefits as it allows less tissue to be excised.

### O-20. The role of the breast care nurse (BCN) specialists in giving results to patients

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The results of pre-operative investigations and post-operative results are normally given to patients by their clinicians. With increasing demands on clinicians' time it was thought appropriate to examine the possible role of BCN specialists in this area. A pilot study was designed to assess the practicalities of BCN specialists giving results to patients both before and after breast surgery and to determine the level of patient satisfaction.

39 patients with either benign or malignant breast disease were invited to join the study. Instead of the results being given to them by their clinician, the patient's BCN specialist verbally presented the results to each patient. These results were also presented in an individualised written format. The informa-