frequent fractioned stools for the CAA group and soiled pads for the CP group. The scores evaluating the QoL general aspects (QLQC-30) were equivalent for CAA and PC. The specific score of QoL for rectal cancer was equivalent for the majority of aspects with only one worst QoL, for the defecation for the CAA group76 (24–100) versus PC group 90 (61–95).
Conclusions: These two salvage techniques give some very comparable results for the continence score and for the QoL. In case of very low rectal tumor, the choice between an intersphincteric resection, that gives the worst functional result of all CAA, and APR with a PC must be done more according to carcinologic(al) criteria than future functional or QoL results, since no major differences seemed to exist between these two salvage techniques.

1436 ORAL

Could surgical radiofrequency ablation of colorectal metastases stimulate dormant micrometastases?

S. Evrard[1], C. Menetrier-Caux[2], C. Biota[3], S. Mathoulin-Pelissier[4], V. Neaud[5], J. Rosenbaum[6]. [1]*Bergonie Institute, Digestive Tumours Unit, Bordeaux, France;* [2]*Leon Berard Centre, Cytokines, Lyon, France;* [3]*Bergonie Institute, Biostatistics, Bordeaux, France;* [4]*INSERM E362, Victor Segalen University, Bordeaux, France*

Background: After hepatectomy, quiescent hepatocytes replicate to restore the liver homeostasis. This process is also known to boost the growth rate of micrometastases sleeping in the remnant liver. Radiofrequency ablation (RFA) destroys mainly tumoral tissue with a small surrounding healthy liver margin. The aim of this study was to evaluate the serum pattern of cytokines involved in hepatic growth regulation after surgical RFA of colorectal metastases in order to evaluate the general inflammatory stress as well as the possible stimulation of dormant micrometastases.
Patients and Methods: Metastases of ten non consecutive patients were intraoperatively destroyed by RFA (Elektrotom®) without concomitant resection. A Pringle manoeuvre was performed in case of lesion more than 30 mm in size or in a paravascular location. Serum sampling were done at D-1, D0 +3 hrs, D1, D2, D3, D5, D7. IL6, TNFα, HGF, VEGF, bFGF, TGFβ1, CRP were assessed by ELISA technique. Livers sizes were measured pre and postoperatively.
Results: IL6 level reached a peak at 3 hours and stayed high during all the study at the opposite of TNFα which was undetectable as bFGF. HGF increased three times at D1 and then decreased until D7 where it was still twice its baseline level. VEGF level increased at D5. CRP was at a high level during all the study. Postoperative CT scan did not exhibit significant increase in liver sizes compared to preoperative assessment.
Conclusion: RFA induces a lower level of systemic inflammation than cryotherapy does. RFA does not lead to a clinically observable change in the liver volume. Nevertheless, it could not be eliminated that the changes in cytokines pattern should stimulate dormant metastases at the same level of risk than resection.

1437 ORAL

The trans-metastasis hepatectomy (with metastases preliminary ablated with radiofrequency): results of a 13-case study of colorectal cancer

D. Elias, D. Manganas, M. Ducreux, P. Lasser. *Gustave Roussy Institute, Surgical Oncology, Villejuif*

Background: Transmetastasis curative liver resection immediately following radiofrequency (RF) destruction is a new technique which allows to propose a curative approach to patients with bilateral unresectable liver metastases (LM), when the only possible future resection plane of a hepatectomy would pass through a LM unhappily sited in this plane. This technique consists in first ablating, using RF, the ill-sited LM, located in the plane of the future section line of hepatectomy, the only possible one for volumetric reason, and then performing the hepatectomy passing through this preliminary ablated LM.
Aim: The aim of this study is to report the feasibility and efficiency of this new approach, called Post-RF-Trans-Metastasis-Hepatectomy (PRFTMH).
Material and methods: Thirteen patients were treated with PRFTMPH between January 2000 and May 2004. Of them had a colorectal primary tumor. The mean number of LM per patient was 10.7.. Preoperative hypertrophy of the future remaining liver was obtained by selective portal vein embolization in 8 patients.
Results: Mortality was 7.6% (one death), and morbidity was 24%. No local recurrence on the site of PRTMPH was observed after a median follow-up of 19.4 months (range: 47–10), demonstrating the efficacy of this technique. All these patients except those who died postoperatively, are currently alive, and the median survival rate has not been reached yet, but is far greater than 20 months.
Conclusion: The PRFTMH is a new and safe technique, combining RF ablation and trans-RF-hepatectomy, which allows to propose a curative approach to some patients with non resectable bilateral LM. More numerous patients are required before to conclude on the positive impact of this new technique.

1438 ORAL

Sensitivity variations related to intectostobrachial nerve section during axillary surgery for the breast cancer

A. Celebic[1], L. Djordjevic[2], R. Dzodic[1], Z. Milovanovic[3], G. Pupic[3], D. Stojiljkovic[1], D. Babic[4]. [1]*Institute of Oncology and Radiology of Serbia, Department of Surgery, Belgrade, Serbia and Montenegro;* [2]*Institute of Anatomy, School of Medicine, University of Belgrade, Belgrade, Serbia and Montenegro;* [3]*Institute of Oncology and Radiology of Serbia, Department if Pathology, Belgrade, Serbia and Montenegro;* [4]*Institute of Oncology and Radiology of Serbia, Data Center, Belgrade, Serbia and Montenegro*

Introduction: The complications of the surgery of axilla (e.g. pain, seroma formation, reduced arm function, anesthesia, hypo- and paresthesia in the axilla, numbness of the arm) appear due to section of the sensory intercostobrachial nerve (IBN), which is often sacrificed during an axillary clearance. This nerve damage may be a cause of significant discomfort in patients treated surgically for the carcinoma of the breast. The aim of this prospective study was to evaluate the advantage of preservation of IBN in order to diminish sensory symptoms.
Materials & Methods: The group of ninety-four patients undergoing axillary dissection for the carcinoma of the breast, hospitalised and operated at the Department of Surgery of Institute of Oncology and Radiology of Serbia (National Cancer Research Center) in Belgrade, in the period from April 2001-August 2002, was recruited to this study, and followed prospectively for the period of three months. According to the surgical interventions of IBN, we divided the patients into three different groups: in first group, the nerve is preserved; in second, the main trunk is preserved and peripheral branches are divided; in third group, the nerve is sectioned. Clinical testing to evaluate changes in tactile sensitivity and pain, using standard neurological methods, were conducted during the immediate postoperative period (4–7 days), after one month and after three months from the surgery. We used different statistical methods: chi-square test, factorial analysis and the means of percentage in order to evaluate these results.
Results: In this group of ninety-four patients, IBN has been preserved in 35 cases, while in 20 patients only peripheral branches have been sacrificed and in 39 of them, nerve has been sectioned. We found the greatest changes in sensitivity in the group of patients with the section of nerve trunk. In the group with section of peripheral branches of the nerve, we found the less intensive alterations. The minimal presence of pain, numbness and paresthesia, although also being presented, has been reported in the group with the preservation of the nerve. The incidence, intensity and the lasting of these changes, significantly increase with sacrifice of IBN ($p < 0.001$ by the chi-square test).
Conclusions: The IBN can usually be identified during an axillary clearance and preservation of this nerve does not appear to affect local recurrence The preservation of IBN during the axillary surgery for the carcinoma of the breast, is strongly recommended in cases where the nerve is not involved by lymph nodes, and where this preservation does not compromise a control of the disease from oncological point of view.

1439 ORAL

Stage migration in breast cancer after the introduction of The Sentinel Node Biopsy Technique – a population based study from the Danish Breast Cancer Cooperative Group (DBCG)

A.H. Madsen[1], P. Christiansen[1], A.R. Jensen[2], M. Düring[3], M. Ewertz[2], S. Cold[4], J.P. Garne[1], J. Overgaard[2]. [1]*Aarhus University Hospital, Dept. of Surgery, Aarhus C, Denmark;* [2]*Aarhus University Hospital, Dept. of Oncology, Aarhus C, Denmark;* [3]*Danish Breast Cancer Cooperative Group, Statistical section, Copenhagen, Denmark;* [4]*Odense University Hospital, Dept. of Oncology, Odense, Denmark*

Background: The sentinel lymph node biopsy technique (SLNB) has rapidly become the standard method in breast cancer patients for detecting metastasis to the axilla. With the technique serial sectioning and staining with immunochemistry in the examination of the sentinel lymph nodes suggests that 10–20% more patients have metastasis to ipsilateral axillary nodes.
Aim: The aim was to investigate if the introduction of SNLB increased the numbers of node positive patients in a population based study.
Methods: We compared a period before SLNB was introduced with a period after the method has become standard procedure in staging the