

RT may not be a cost effective treatment in this population unless it results in a recurrence rate at least 5% lower in absolute terms than those treated without RT.

O-20 Surgical opinion of cosmetic outcomes following breast conserving surgery for primary breast cancer

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Several studies have shown that breast conserving surgery [BCS] (wide local excision followed by radiotherapy) and mastectomy results in equivalent survival rates. Thus BCS has potential advantages of better cosmesis and body image, with subsequent improvement in quality of life. Results however often fall below expectations.

The aims of this study were to analyse the cosmetic outcomes following BCS for primary breast cancer, comparing the opinions of Consultant Surgeons (CS) and Non-surgical practitioners (NSP).

Post-operative photographs (3 different views, standard conditions and positions) of 50 patients (median age 61, range 42–84) with primary breast cancer, who had been treated by wide local excision and radiotherapy were evaluated on a standardised 4 point grading system by 4 consultant breast surgeons, 1 plastic surgeon, 1 breast physician, 3 nurses and 1 lay person. The assessors also gave an overall score out of 10.

	Surgeon	Non-surgeon	P value
Breast shape rated as "Excellent"	44%	28%	<0.001
Scarring rated as "Excellent"	27%	23%	0.353
Nipple position rated as "Excellent"	32%	25%	0.138
Breast position rated as "Excellent"	47%	26%	<0.001
Symmetry rated as "Excellent"	33%	24%	0.038
Median overall score	8	7	0.004

Increasing weight of specimen adversely influenced both CS and NSP opinions ($r = -0.201$, $P = 0.002$ and $r = -0.175$, $P = 0.007$).

Consultant Surgeons universally scored the outcomes of breast conserving surgery more highly than non-surgeons. Both groups were more satisfied if the resected specimen was small.

O-21 Residual disease after excision of ductal carcinoma in situ of the breast: a multivariate regression analysis of predictive factors

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Background: Recurrent disease after DCIS treatment may result from outgrowth of the same disease; "residual disease"; or a new primary tumour. The only definitive method of detecting residual disease involves further surgery. Reliably predicting residual disease and the need or avoidance of further surgery would usefully guide surgical management.

Methods: 432 consecutive patients with DCIS and definitive assessment for residual disease were assessed. Patients undergoing mastectomy as the initial surgical procedure were excluded. Multiple clinical factors were prospectively recorded and multiple histopathological features were reassessed by a single pathologist. Univariate predictors of residual disease were submitted to multivariate logistic regression analysis to identify independent predictors of residual disease.

Results: Of 432 patients, 201 (46.5%) had residual disease. 205 (47%) initial excision margins were involved; single margin involvement in 84 specimens, the remainder

had two or more involved margins. Significant univariate predictors were; margin status, extensive DCIS, pathological size, comedonecrosis, micropapillary histology, nuclear grade, Van Nuys Pathological Classification, volume of excision, HRT use, and presentation mode. Multivariate logistic regression assessed a suitable model for residual disease prediction. Margin status [OR 2.5 (95% CI 1.16–5.39)], extensive DCIS [OR 2.16 (95% CI 1.49–3.14)], micropapillary [OR 2.29 (95% CI 1.41–3.73)] and comedonecrosis histology [OR 1.66 (95% CI 1.17–2.36)] were independent predictors of residual disease.

Conclusions: Identifying a group of DCIS patients at highest risk of residual disease is worthwhile. Patients with one or more risk factors may benefit from re-excision, mastectomy, or radiotherapy, to reduce recurrence. This study reports a large consecutive series with consistent pathological reporting.

O-22 Mode of recurrence of operable invasive breast cancer with reference to NICE guidelines

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Study aims: NICE guidelines suggest breast cancer follow up by specialists should cease after 2–3 years. This study examines type and mode of presentation of recurrence in a consecutive series presenting with operable invasive breast cancer.

Patients and Methods: 1113 patients received treatment between January 1995 and December 2004 and were followed under strict protocol in designated cancer follow up clinics by Breast Physicians. Patients attended every 3/12 for 12/12, every 6/12 for second year and annually thereafter. Recurrences were entered prospectively onto a computerised database. Patients were divided into 3 groups.

Group A: Disease detected at specialist follow up clinic. Group B: Direct GP referral for recurrence Group C: Recurrence detected by routine mammography

Results: 168 patients have recurred. 75 (45%) recurred with loco-regional disease alone (36 local, 33 regional, 6 combined); 76 (45%) with metastases alone and 17 (10%) with combined disease. Median follow up = 63 months. Lost to follow up <2%.

Mode of presentation of recurrence

Group A	113 (67%)
Group B	47 (28%)
Group C	8 (5%)

Time to recurrence

<12 months	28 (17%)
12–24 months	57 (34%)
25–36 months	29 (17%)
>36 months	54 (32%)

Conclusion: 67% of all recurrences were detected by specialist follow up and 32%, to date, occurred after 3 years. This suggests that NICE guidelines may need revisiting.

O-23 Patient led breast cancer follow up

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We recently introduced patient-led follow up (PLFU) for low risk breast cancer patients. The aim of this study was to audit patient satisfaction with this protocol.

A questionnaire was sent to 114 consecutive, low risk (post-menopausal, node negative, NPI < 3.4, DCIS