The sensitivity, specificity, positive predictive value, negative predictive value and accuracy were the following: 88.6%, 86.4%, 86.7%, 93.9%, and 91.3% for intraoperative imprint cytology; 86.4%, 100%, 100%, 93.2%, and 95.2% for frozen section examination; 97.7%, 100%, 100%, 98.8%, 99.2% for intraoperative imprint cytology and frozen section examination together.
**Conclusions:** Although the difference is not significant (p = NS, chi-squared test) the combination of intraoperative imprint cytology and frozen section examination may improve both the sensitivity and accuracy of sentinel lymph node procedure, with a very low (<1%) false-negative rate, and should be suggested in all patients undergoing surgery for breast cancer in whom the sentinel lymph node procedure is required.

**2074** POSTER

**The value of sentinel lymph node biopsy in DCIS(M) of the breast**

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**Background:** Ductal carcinoma in situ (DCIS) refers to the preinvasive stage of breast carcinoma and should not give axillary metastases. It's diagnosis, however, is subject to sampling errors. The role of sentinel lymph node biopsy (SLNB) in management of DCIS or DCISM (with micro-invasion) remains unclear. The purpose of this study was to review our experience with SLNB in DCIS and DCISM.
**Materials and Methods:** A review of 51patients with a diagnosis of DCIS (n= 45) or DCISM (n= 6), who underwent SLNB and a definitive breast operation between January 1999 and December 2006, was performed.
**Results:** In 10 of 51 patients (19.6%) definitive histology revealed an invasive carcinoma. SLN (micro)metastases were detected in 5 out of 51 (9.8%) patients, of whom 2 had a preoperative diagnosis of grade III DCIS and 3 of DCISM. Three patients (75%) had micrometastasis (<2 mm) only. In 2 patients, histopathology demonstrated a macrometastasis (>2 mm). All 5 patients underwent axillary dissection. No additional positive axillary lymph nodes were found.
**Conclusions:** In case of a preoperative diagnosis of grade III DCIS or a grade II DCIS with comedo necrosis and DCIS with micro-invasion a SLNB procedure has to be considered because in almost 20% of the patients an invasive carcinoma is found after surgery. In this case the SLNB procedure becomes less reliable after a lumpectomy or ablation has been performed. SLN (micro)metastases were detected in nearly 10% of the patients. The prognostic significance of individual tumour cells remains unclear.

**2075** POSTER

**Does the estrogen receptor status influence survival of pCR breast cancer (BC) patients (pts) after primary chemotherapy (CHT)? Results of a multicenter study**

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**Background:** Existing studies show that the BC pts who benefit the most from neoadjuvant CHT are those who achieve a pathological complete response (pCR). We previously demonstrated that no difference exists between pts with no residual disease (pT0) and those with microscopic residual (pTm) in the breast, according to Sataloff's Classification. Recent data have suggested that ER-ve status may be predictive of pCR, but few data are available concerning the clinical outcome of pCR pts according to hormone receptor status.
**Patients and Methods:** We analysed 45 out of 308 pts with initial clinical T2−3 (18 pts, 40%) and T4 (27 pts, 60%) BC, who achieved pCR, according to Sataloff's classification (pT0+ pTm), following different kinds of neoadjuvant CHT in the period 08/1989–08/2006. Median age was 47 years (29−68), 29 pts (64%) have ER-negative tumours, 35 (77.7%) PR-negative. All pts received anthracycline-based neoadjuvant CHT, even standard (47%, q21) or intensified (53%, q14). Median number of administered cycles was 5 (2−6).

Table 1

| | ER−ve | ER+ve | p |
|---|---|---|---|
| DFS % | 89.7 | 62.5 | 0.01 |
| OS % | 93.1 | 68.8 | 0.02 |

**Results:** At a median follow up of 91 months (1–205), DFS was 89.7% in ER−ve pts and 62.5% in ER+ve (p = 0.01). OS was 93.1% and 68.8% in ER−ve and ER+ve pts, respectively (p = 0.02). Results are reported in Table1.
**Conclusion:** Even if limited by the small number of pts, our results seem to suggest that, when ER−ve pts achieve pCR following neoadjuvant chemotherapy, they obtain a significant improvement in their clinical outcome. Correlation between ER and PgR status are currently under evaluation. Larger series are expected to confirm our results.

**2076** POSTER

**In early breast cancer, obesity is no contraindication for sentinel lymph node biopsy under local anaesthesia without sedation**

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**Background:** Sentinel lymph node biopsy is the standard of care for staging the axilla in invasive breast cancer. Obesity has been identified as a factor with an inverse relationship to success. We studied whether obesity was a detrimental factor in lymphatic mapping under local anaesthesia without sedation, a procedure which has been standard of care in our teaching hospital.
**Methods:** We reviewed sentinel lymph node mapping in a consecutive series of 359 sentinel lymph node procedures under local anaesthesia between November 2000 and April 2003. We used a combined technique (radioisotope and blue dye) to detect SLN's. Failure was defined as the inability to identify any nodes either by blue dye or by handheld gammaprobe. Body-mass index (BMI) was measured for each patient by height and weight data (kg/m2). Clinical stage T1N0 to T3N0 were included.
**Results:** The median age was 59 years; range 29−97 yrs). The median BMI in our population was 25; range 18−50. 59 Patients (16%) had a BMI >30. Overall, only one failure was observed, which was encountered in a 83 years old woman with a BMI of 30. So the overall success rate was 99.99%.
**Conclusion:** Obesity has no significant effect on sentinel node identification under local anaesthesia without sedation.

**2077** POSTER

**Immediate reconstruction with latissimus dorsii flap in breast conservative treatment**

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**Background:** Although breast conserving surgery is the treatment of choice for small breast cancer, 25% of patient who underwent breast conservation have a poor cosmetical result. The use of latissimius dorsii flap not only allows to avoid a unfavorable aesthetic outcome but can extend the indications to conservative treatment even if the tumor size/breast size ratio is inappropriate. Aim of the study is to evaluate the oncological and cosmetic result of this procedure.
**Materials and Methods:** Since 2001 to 2005, 60 cases of latissimus dorsii flap were used in immediate reconstruction of breast conservative treatment. The median follow up was 51.3 months (range 71−20). Patients age ranged from 33 to 62 years. The tumor size average was 33.64 mm (54−18). In 10 cases the flap was totally deepithelized and used for exclusive glandular replacement. In these cases the evaluation of the flap status was performed with MRI. The aesthetic outcome was evaluated by the surgeon, the nurse and the patient itself: the score ranged from poor to very good.
**Results:** No local relapses, in the routinary follow up, was diagnosticated in this series of patients. The margins of resection were involved in 4 cases (6.6%):2 cases underwent to mastectomy and 2 were treated with radiotherapy boost. The cosmetic score was for 20 patient very good, for 25 good, for 10 satisfactory and 5 poor. The use of deephitelized flap improve the cosmetic results (10 cases to 10 rated very good). No major complications, immediate and late, were observed.
**Conclusion:** These data support the use of latissimus dorsii flap following breast conserving surgery. This technique is oncologically safe, allows very satisfactory levels of reconstruction and represents a good, but selective, integration between oncological and reconstructive procedures.