of the bladder neck, have made radical prostatectomy for T1c and small T2a lesions to rather be defined as a "total" prostatectomy with a very marginal resection of the gland. The surgical technique performed by the author is not an intrafascial nerve sparing procedure but rather an enucleation (extrafascially) of the prostate gland out of the neurovascular bundles.
For the locally advanced cases wide excision of the neurovascular bundles is mandatory and also this technique is extensively described.
Conclusions: Total prostatectomy with preservation of continence and potency and radical prostatectomy for locally advanced prostate cancer belong to the modern surgical approach in the battle against localised and locally advanced prostate cancer.

67 INVITED

Personalized surgical treatment for early breast cancer

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Definition of early breast cancer: For this purpose EBC is defined as T1/2 (<3 cm) N0/1. The issue of neo-adjuvant chemotherapy in larger breast cancers is not part of this presentation.
What are the factors to take into account to enable a fully personalised loc0-regional treatment in a woman with breast cancer?
Optimal imaging:
– mammography (digital), magnification views, ultrasound, MRI (if this can be afforded it is very helpful to select patients for breast conservation and to exclude multifocality etc.)
– Image guided histological and cytological diagnosis of the index lesions.
– Imaging of the axilla: ultrasound (mandatory, if suspicious FNA Cytology of nodes)
– PET-scan (not considered to be standard).
Patient related factors:
– Age, the younger the patient, the higher the risk for local relapse and second primaries
– Family history: hereditary breast cancer likely?
– Patient preference after optimal information
The surgical options:
– Wide local incision with the intention of a 1 cm free margin including reconstruction of the breast where dead space should be kept to a minimum. Any oncoplastic technique should always be applied.
– Skin sparing mastectomy (with or without nipple sparing) and immediate reconstruction
– Sentinel node biopsy (if preoperative assessment is negative)
– Axillary lymph node dissection (if pre lymph node assessment or SN is positive (> isolated tumor cells)
– Mastectomy with or without ALND
– Thermo ablation of the tumour is to be considered experimental.
Histological work-up. The following steps are indispensable:
– Marking the specimen for orientation
– Full margin assessment
– Paraffin and fresh frozen tumour samples to enable RNA/DNA analysis including storage.
The report should include minimally:
– Type of breast cancer (IDC, ILC, medullary, etc)
– Margins: minimal margins, close, involved, focally involved and more than focally involved,
– Differentiation grade, vascular invasion
– ER, PR and HER-2 testing is mandatory; P53, KI 67 helpful but not standard
Radiation therapy:
– Whole breast including yes or no boost (partial breast irradiation is in general considered to be experimental)
– Internal mammary chain / supra clavicular (as elective treatment not generally applied)
– Axilla (as alternative for ALND)
– Axilla and peri clavicular area in node positive disease (indications are shifting!)
Systemic therapy:
– Adjuvant hormonal therapy (if endocrine responsive) and/or chemotherapy is able to reduce local relapse rates by 30−50%.
All these different steps should be taken and discussed with the patient, leading to optimal local regional control breast cancer with optimal cosmetic outcome. Loco-regional relapse rates should be kept within 1% per year and cosmetic results should be good to excellent in over 80% of the women.

68 INVITED

Personalized surgical treatment for sarcoma

P. Hohenberger. *Klinikum Mannheim der Universität Heidelberg, Head Section of Surgical Oncology and Thoracic Surgery, Mannheim, Germany*

During this presentation, I would like to discuss my personal beliefs and decision making process that includes the following steps:
1. Is it really sarcoma?
2. Is it a molecularly characterized sarcoma with distinct treatment options (DFSP, GIST, myxoid/round cell liposarcoma, angiosarcoma)
3. Is it low grade or high-grade?
4. If it is low grade, is it primary respectable?
5. Is a plastic or reconstructive procedure required?
6. If it is high-grade, which options for combined neoadjuvant/adjuvant treatment fits best to location of the tumor, Karnofsky status of the patient, availability of technique?
7. In case postoperative irradiation of the tumor will be required with high probability, any effort should be performed to schedule it preoperatively, this is particularly of interest in retroperitoneal sarcoma.
8. High-grade sarcoma of the limb with deep location or extracompartimental extension require preoperative treatment, preferably by isolated limb perfusion with TNFa and melphalan, alternatively by a combined radiochemotherapy.
9. Any locally recurrent tumor following adequate resection must be considered for combined modality therapy!
10. Resection following preoperative radio-/chemotherapy or ILP should use the preoperative imaging findings to decide on resection margins.
11. Long-term functional outcome needs to be assessed by validated tools.
12. Most important: explain the schedule of treatment and the time required until final recovery from rehabilitation to the patient and his/her family. This may take half a year or even longer. Adapt your schedule to the ability of the patient to cope with the sarcoma.

Special session (Tue, 25 Sep, 09:00−11:00)
The European Branch of the International Society of Paediatric Oncology (SIOP Europe)

69 SIOP-Europe Award

Teenage and Young Adult Cancer (TYA) "The Forgotten Tribe"

T. Eden[1], J. Birch[1], L. Fern[2], J. Whelan[2], M. Rogers[3], S. Smith[3].
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All of the advances in the survival of children with cancer has highlighted the relative lack of focus and understanding of TYA cancer. We are making a concerted effort to focus on: the absolute/relative incidence of tumours in those aged 13−24 years; aetiology; assessing if referral and diagnosis is timely and appropriate; who should treat and care for TYA?; why is trial entry so low?; does biology affect outcome?; why is survival worse than in childhood?; and is there an optimal environment for care. Preliminary data demonstrates that TYA cancer constitutes 1% of all malignancy (nearly twice as much as in childhood, 2000 versus 1200/year in UK), but 13% of all deaths. 10% of the tumours are the tail of those seen in childhood, 30% of the tumours peak in this age, but 60% are early onset adult tumours. The pattern provides clues to aetiology. Delay in diagnosis has been identified but professional delay is greater than patient for all tumours studied. Ways to reduce delay are being explored. Survival has improved 1970–2000 but less than in childhood. The contribution of biology and treatment will be explored. Trial entry falls off exponentially with increasing age. Paediatric and adult oncologists/nurses must work together to provide timely, optimal care for this needy group.

70 INVITED

Recent childhood cancer survival in Europe

G. Gatta.

Abstract not received.