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Preoperative procedures and surgical treatment of nonpalpable breast lesion

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Background: Even in the breast structure without clinical signs of tumor exists for an occult malignancy. Nonpalpable breast lesion can be detected by mammography, breast ultrasound or MRI. Together with open surgical biopsy and histological examination, the diagnosis of nonpalpable breast tumor is more reliable.

Aim: Study was to evaluate the screening of nonpalpable breast lesion by stereotactic needle localization, surgical biopsy and specimen mammography (national Project 1649).

Methods: Combining method of localization of clinically nonpalpable breast masses, marking out the lesion and using stereotactical needle localization, surgical biopsy and specimen mammography. Criteria for inclusion into this study were mammographycally discovered abnormal breast condensation, disturbed architecture, microcalcification, stelate tissue alteration. Computerizing guiding was used, and for marking out the lesion x-ray needle was used. Surgical biopsy was performed by economically excision and the specimen was send to specimen mammography. Frozen section examinations were obligatory.

Results: In period from 2005–2007, 143 pts were included in experimental group (SG), and 136 pts in control group (CG). Median age was 52 in SG, and 50 in CG. In study group 81 (56.6%) pts had nonpalpable tumor and palpable breast mass was found in 46 (32.4%) of pts. Microcalcification was present in 92 (64.3%) pts, and 32 (22.3%) pts had no such mammographic sign. Intraoperative specimen mammography was performed in 113 (79%) pts, with microcalcification BIRADS 4 a.b. Manually marking out was performed in 82 (57.3%), and stereotactical marking out was performed in 31 (21.6%) pts. Marking in center of lesion was in 23, at the border line of the lesion in 5, and out of the lesion in 4 pts. Frozen section analysis showed benign lesion in 82 (57.3%), and malignant breast lesion in 60 pts (41.9%). Segmentectomia was performed in 69, mastectomy by Madden in 31, primary reconstruction of breast in 9, QUAR with axillar cyrrage was performed in of 20 pts. HP diagnoses: invasive carcinoma in 43, carcinoma in situ in 9, and 8 pts had microinvasive carcinoma. In 18 pts tumor was less than 10 mm in size, in 25 pts tumor was bigger than 10 mm, and in 5 microtumor diameter up to 3 mm was diagnosed.

Conclusion: False positive and false negative results were revealed in up to 5% pts. Introducing this method into clinical practice could increase the precision of surgical intervention in breast cancer.

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Identification and releasing of the intercostobrachial nerve and the lateral thoracic vein in the beginning of axillary dissection facilitates their preservation

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Background: The preservation of neurovascular elements passing through the axillary fibrofatty tissue (the intercostobrachial nerve and the lateral thoracic vein (ICBN and LTV)) could be techniqualy demanding if an en bloc axillary dissection is performed in the conventional way. In this paper we describe a surgical technique for more successful preservation of these elements, by which fragmentation of the axillary fibrofatty tissue is planned and performed “in advance”. The techniques of axillary sampling biopsies, where lymphatic vessels are always divided, have shown that cutting of the lymph routes does not increase the risk of local regional recurrence.

Material and Methods: The group of 22 consecutive breast cancer patients (stage I and II) was operated on using the surgical technique described in this paper, in a prospective study. Results in preserving the neurovascular elements were compared to an earlier series of conventionally operated patients, with the intention of preserving the ICBN and the LTV.

Results: In an earlier series of 65 conventionally operated patients, with the intention of preserving the ICBN and the LTV, the nerve was preserved in 53 patients (81, 5%), and the vein in 22 pts. (34%). After adopting and applying the above-described technique, in a series of 22 consecutive dissections, the nerve was spared in 22 patients (100%), and the vein was spared in 21 pts. (95%).

Conclusions: Using the technique for the identification and release of the ICBN and the LTV at the beginning of dissection, without paying attention to en bloc removal of the fibrofatty tissue, it is possible to improve the functional effects of the axillary dissection.

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Axillary dissection in breast cancer – a large retrospective study indicates significant reduction in sequelae by conservation of intercostobracchial nerves

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Background: The axillary dissection (AD) often has serious sequelae which spoil the quality of life. Therefore the necessity of axillary clearance has been challenged repeatedly. Randomized studies preserving intercostobracchial nerves have been performed several times but are difficult to perform and not large enough. None have shown significant benefit, but all have had a positive trend.

Material and Methods: A continuous population of 340 breast cancer pts with AD have been followed in the years 2000−05. They belong to three groups: 1. Operated by specialist 1999–2005, N = 138. 2. Operated by learning surgeons in the department and taught the same technique performed by the specialist, N = 84. 3. Other surgeons during 1994−99, N = 118. The surgical technique has aimed on preserving intercostobracchial nerves and also some vessels which otherwise are severed in an en bloque approach. The pts have yearly 2000−05 filled in a questionnaire, 17 questions, all with a VAS-scale 1−10. The 17 questions have been grouped into 4 key issues: 1. Lymphoedema. 2. Movement of the shoulder. 3. Sensibility. 4. Quality of life. Statistics have used SPSS 14.0.

Results: The specialist removed more nodes and more positive nodes than the learning surgeons, who again removed more and also more positive nodes than the other surgeons. In spite of this there were fewer sequelae of all categories among the specialist’s pts compared with the other surgeons, and the learning surgeons had fewer sequelae than the other surgeons. Analysing pts without any sequelae this was the situation in 56%, 42% and 25% in the tree groups. All the differences were statistically significant with two exceptions but the same trend: Node number between specialist and learning, and difference in movement between learning and other surgeons.Discussion: The material is large and can partly compensate for lack of randomization which no longer seems ethically correct. The results are even more convincing because more pts in the specialist group are treated with radiation.The results strongly indicate that a gentle technique preserving the nerves and some vessels reduces the sequelae.

Conclusion: En bloque dissection should be avoided.

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A new myofasciocutaneous flap for immediate breast reconstruction and complicated aesthetic breast implant

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The author presents a new surgical method for immediate breast reconstruction in nipple-skin sparing mastectomy or to solve complicated breast implant in order to achieve an immediate fully projected new breast.

This technique was performed in forty-six patients since 2000, with average follow-up of three years.

Using permanent implant or filled expanders, an umbilical and inframmary fold approach associated to axillary’s video-endoscope dissection, of an inverted myofascial extended sheet of the abdominal portion of the attached Rectus abdominal-External Oblique muscles, adding the Latissimus dorsi muscle, we were able to assure a fully and well protected implant coverage without any other scar than the mastectomy site.

In order to recover the nipple-areola complex in some patients, we used an abdominal skin attached to the External Oblique muscle, with no necrosis.

The technique consists in a peri-prosthetic myoplasty, unifying, in a geometric fashion, the superior third or even a half portion of the bilateral Rectus Abdominal sheath, the External Oblique muscle, Latissimus dorsi muscle, Anterior Serratus, the Pectoralis Minor and the Pectoralis Major muscles.

Only one significant capsular contracture (Baker-III) in all series was observed, even when the large majority of the patients (32) were submitted to aggressive postmastectomy radiotherapy.

The multiple muscle recipe has improved dramatically the average volume of the pocket thus ensuing a considerable drop of the usual complications.