Extended LDF was used in 32 cases (24%), 23 after mastectomy and 9 after BCT. In 87/113 (77%) of total breast reconstructions, an implant was used behind the flap.

Re-operation rate for capsular contracture was 4.4% in the group that had mastectomy after BCT with radiotherapy, and 5.5% in the group that had mastectomy only.

Conclusions: Latissimus dorsi flap is safe for immediate or delayed breast reconstruction. Its use in BCT did not interfered with the oncological follow up. The rate of re-operation due to capsular contracture is low, even when radiation therapy is delivered.

543 Poster

Superior pedicle mammaplasty with a deepithelialized inferior breast pedicle for immediate reconstruction of quadrantectomy defects in patients with breast cancer or tissue defects

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Background: Superior or inferior based pedicle mammaplasties are commonly used in oncoplastic breast cancer surgery.

We describe a combination of these techniques with a superior based pedicle mammaplasty peformed and an inferior based (either de-epithelialized or with a skin island) pedicle used to reconstruct a defect caused by tumor resection.

Methods: 76 patients underwent a superior based pedicle mammaplasty and defect reconstruction with an inferior pedicle. Indication for surgery were primary (n = 66) or recurrent (n = 6) breast cancers of the ipsilateral (n = 70) or the medial quadrants of the contralateral (n = 2) breast, corrections of defects following cosmetic mammaplasties (n = 3) or reconstruction of defects resulting from tissue necrosis following cancer surgery (n = 1).

Results: 5/76 patients had to undergo a secondary mastectomy (4 with immediate reconstruction) due to involved margins (n = 3, all were DCIS high grade) or multicentric carcinoma (n = 2), one patient had a local re-excision for involved margins.

2 patients developed a fatty tissue necrosis, no local recurrences were found after a mean follow-up of 38 months.

Conclusions: The technique of a superior pedicle mammaplasty combined with immediate reconstruction of the quadrantectomy defect by an inferior pedicle allows the use of oncoplastic mammaplasty techniques even in patients with smaller breasts, reconstrcution of defects high up in the upper medial or upper lateral quadrant (even when resected skin has to be reconstructed) and the coverage of defects an the thoracic wall and the medial quadrants of the contralateral breast.

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Oncoplastic techniques in Asian women with small breasts

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Backgrounds: Oncoplastic surgery, combined oncologic extirpation of the tumor with plastic surgical reconstruction of breast shape and symmetry, is a new surgical procedure for the treatment of breast cancer and increasingly being used for breast-conserving surgery (BCS). It provides the opportunity to improve the final cosmetic results and to extend the indications for conservative treatment with oncologic safety.

Material and Methods: After BCS was preceded, different oncoplastic techniques were selected depending on the location and size of the tumor within the breast as well as the size of breast itself. Partial mastectomy with round block technique, with glandular flap and with bilateral reshaping using reduction mammoplasty technique, tennis racket operation, J mammoplasty and modified inverted T reduction mammoplasty were chosen. In order to improve the cosmetic outcome, repositioning of the nipple areola complex (NAC) or reshaping of the contralateral breast may be considered additionally.

Results: Patients undergone oncoplastic surgery have been highly satisfied with the cosmetic results. There was no significant postoperative complication during the follow up periods. In addition, oncoplastic techniques extend the indication for BCS to tumor at high risk for a poor aesthetic result because of their location within the breast such as central region or lower quadrant.

Conclusions: Even though small breast, we can apply oncoplastic techniques to these patients. The combination of plastic surgery techniques with oncologic surgery (oncoplastic surgery) is new concept in breast cancer treatment. In selected cases, this approach has allowed us to perform wide resections and obtain good oncologic control with favorable cosmesis. In conclusion, oncoplastic surgery is expected as new cornerstone for the reconstructive method for breast cancer.

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Quilting effect for the prevention of seroma formation following immediate LDMCF reconstruction after quadrantectomy

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Background: Latissimus dorsi myocutaneous flap (LDMCF) is a commonly used technique for breast reconstruction following breast conserving surgery. However, this technique has a high incidence of donor site seroma. The aim of this study is to evaluate the effect of donor site quilting on seroma formation.

Material and Methods: A retrospective review of 95 patients who underwent immediate breast reconstruction with LDMCF from May of 2006 through February of 2007 was performed. The patients included in this study were divided into Group A which was comprised of patients in which only a closed suction drain was used and Group B which was comprised of patients in which quilting and a closed suction drain was used. The outcome measures were age, body mass index (BMI), mastectomy volume, lengths of drainage, total volume of postoperative seroma, length of hospital stay and incidence of postoperative aspiration.

Results: In Group B, total amount of seroma ($p < 0.05$), duration of drain and length of hospital stay were significantly reduced. However, the incidence of postoperative aspiration was not different between Group A and Group B ($p = 0.06$).

Conclusions: The quilting technique reduces the volume of postoperative seroma and it may be a useful method the prevention of seroma after LDMCF.

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Central lumpectomy with resection of the nipple-areolar complex for retroareolar or central breast cancers

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Background: This study was conducted to evaluate the outcome of breast-conserving therapy by means of a breast conserving surgery including nipple-areolar resection and postoperative radiation therapy in patients with retroareolar or central breast cancers.

Materials and Methods: A total of 14 patients with retroareolar or central breast cancers, aged 39 to 63 years, treated between May 2004 and January 2008 were identified. Ipsilateral breast recurrence, survival, and cosmesis were analyzed. Treatment was comprised of a complete excision of the nipple-areolar complex including the underlying breast tissue with tumor free margins by intraoperative frozen sections, followed by external beam irradiation to the whole breast (50 gray in 25 fractions) and tumor bed (10 gray in 5 fractions). We used wedge closure, advanced flap, or Grisotti-flap closure for the reconstruction of the surgical defect. The mean follow-up period was 24.6 (2 to 48) months.

Results: At histologic examination, 9 had invasive ductal carcinoma (IDC); in the remaining 5 had ductal carcinoma in situ (DCIS). Only 1 had atypical ductal hyperplasia at intraoperative frozen surgical resection margin; remaining 13 were free from the tumor. The mean tumor size was 1.6 cm (range, 1−3 cm) and the distance from the nipple was 0−1 cm by pathology report. Of 14 patients, 4 (28.6%) were axillary node positive. A total of 8 of 9 patients with IDC received adjuvant cytotoxic chemotherapy according to the lymph node status (CMF or anthracycline with or without taxane), followed by radiation therapy. 13 (92.9%) of 14 patients with hormone-receptor positive were given tamoxifen or anastrozole according to menopausal status. With a mean follow up of 24.6 months, all 14 patients are alive and free of disease. Cosmetic results are good to excellent in 13 (92.9%) patients, as judged by both the patients and the surgeons.

Conclusion: Our study suggests that retroareolar or central breast cancers can be successfully treated with breast conserving therapy including nipple-areolar resection and postoperative radiation therapy, and with acceptable cosmesis.