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Definitive surgery of breast carcinomas diagnosed by mammographic wire-guided biopsy

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Background: Mammographic screening has decreased mortality from breast cancer. We compared surgery in carcinomas diagnosed after mammographic wire-guided biopsy (MWGB) with surgery of carcinomas diagnosed after palpable lump.

Material and Methods: We retrospectively analyzed 203 breast carcinomas diagnosed by MWGB, of a total of 483 carcinomas (years 2003 to 2005).

Results: Mean age of carcinomas diagnosed by MWGB (59.7±12.0 years) was similar to the diagnosed after palpable lump (61.6±14.3). From 50 to 65 years old (range of age of mammographic screening in those days) 50.7% of carcinomas were mammographically detected, 38.7% and 36.9% in the younger and older of that range of age respectively ($p = 0.008$). In situ (85%) and microinvasive (62.5%) carcinomas were more frequently diagnosed after MWGB than after palpable lump, whereas invasive carcinomas were diagnosed in 65% after palpable lump ($p = 0.0001$). There was no difference between carcinomas diagnosed mammographically and the rest regarding histological type (percentages of ductal, lobular or other histological types of invasive carcinomas). Breast conserving surgery (BCS) rate was 66.5% of mammographically detected carcinomas and 46% of the rest ($p < 0.0001$). In the 54 ductal carcinomas in situ (DCIS) BCS rate was 58.3% in the mammographically diagnosed and 50% after palpable lump ($p = 0.69$). In invasive ductal carcinomas, BCS rate was 68.3% after mammographical abnormality, and 47.2% after lump ($p < 0.0001$). 70% of invasive carcinomas smaller than 1 cm, were wire-guided diagnosed. Axillary lymph node dissection (ALND) was performed in 81.7% of all invasive carcinomas (not performed mainly for advanced age or health pathology). In invasive carcinomas, 81% of not affected axillary lymph nodes was found in wire-guided diagnosed carcinomas, and 49% after palpable lump ($p = 0.0001$).

Conclusions: 42% of carcinomas were diagnosed by MWGB. Invasive carcinomas diagnosed by MWGB, were smaller and had only 19% affected axillary lymph nodes. Years ago, breast cancer control depended entirely on the effectiveness of treatments. Nowadays, it is greatly influenced by the possibility of diagnosis at early stages.

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Surgical margins in palpable and non-palpable breast cancer tumors with the ROLL approach

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Background: Standard localization techniques of the nonpalpable breast lesions have several disadvantages. Radioguided occult lesion localization (ROLL) was recently proposed as a better alternative resulting in wider surgical margins The objective was to determine the effectiveness of ROLL technique in non-palpable tumors compared with conservative surgery in palpable tumors.

Methods: We retrospectively reviewed breast cancer hystologies done with ROLL technique between March 2005 and September 2006, and palpable breast cancers in which conservative surgery was the first treatment option for the same time period. To ascertain surgical margin status we followed the Northamerican National Surgical Adjuvant Breast and Bowel Project. We compared tumor size, margin status and mean distance from tumor. We collected histological type and grade, and the presence of extensive intraductal carcinoma (EIC) for invasive tumors to determine if these are risk factors for failing to obtain free margins.

Results: A total of 114 patients were reviewed (58 ROLL technique and 56 with conservative surgery in palpable tumors). The size of palpable tumors was significantly bigger (mean 17.54 mm, range 9−30, SD 5.13) than in the group intervened with ROLL technique (mean 13.97, range 4−30, SD 6.51). The distribution of free, close and affected margings was similar in both groups. Mean free margin distance was also similar between both techniques (palpable group 5.94 mm, range 2−10, SD 2.99 and ROLL group 6.18 mm, 2−13 and 2.80) Regarding potential predictive factors that were considered (histological type [lobular infiltrative] and grade, and presence of EIC) only the last one was associated with a higher risk of obtaing close or affected margins (Table 1) in both groups.

Conclusions: Clinical results of ROLL for nonpalpable breast cancer are comparable with those for conservative resection of palpable tumours.

Table 1: Presence of extensive intraductal carcinoma (EIC).

	Free margins	Close or affected	P value Fisher's test
Palpable with EIC	0	10	0.00
ROLL with EIC	1	5	0.02

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Patients' preference and type of early breast cancer surgical treatment during 2006 at the Institute for Oncology and Radiology of Serbia – single center experience

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Introduction: Each year about 3700 women in Serbia are newly diagnosed with breast cancer (BC). About one fourth to one third of these women started their treatment at the Institute for Oncology and Radiology of Serbia (IORS). We analysed the surgical treatment of all newly diagnosed BC patients in 2006 (biopsies for advanced stages were excluded).

Patients and Methods: Multidisciplinary approach is routinely applied to all BC patients treated at the IORS regardless of the disease stage, including decision about the surgical treatment in early stages. A final decision which kind of operation was to be done further was discussed with each patient according to disease stage and patient's preference. The source documents for this analysis were the multidisciplinary team decision forms and surgical reports.

Results: One thousand two hundred and forty seven women were diagnosed with BC in 2006 at the IORS and 932 of them were surgically treated. Median age was 58 years (range 26−90) with 25% patients ⩽50 years. Twenty eight percent of patients were diagnosed in stage I, 27% in stage IIA as well as in stage IIB, and 18% in stages III and IV. The following surgical interventions were done: modified radical mastectomy (MRM) in 441 patients, subcutaneous mastectomy with immediate reconstruction (SM-ImR) in 109 patients, wide excision with axillary node dissection (WE-AND) in 328 patients, wide excision (WE), and simple mastectomy (SM) in 46 and 8 patients, respectively. The subgroups of patients in stages I-IIB (n = 764) were separately analyzed in relation to patients' age (⩽35, 36−50, 51−65, ⩾66 years) and type of surgery [MRM vs. SM-ImR vs. breast conserving surgery (BCS): WE+WE-AND]. These results are shown in the Table.

Age (years)	MRM		SM-ImR		BCS		Total (n)
	n	%	n	%	n	%	
⩽35	0	0%	9	47%	10	53%	19
36−50	49	27%	49	27%	81	45%	179
51−65	162	47%	31	9%	149	44%	342
⩾66	105	47%	1	0.4%	118	53%	224

Conclusion: Our results show that younger patients with stage I and II BC are more likely to accept SM-ImR than older ones, while breast conserving option was equally acceptable across all patients' age groups.

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Ultrasound guided infiltration of local anaesthesia in medically unfit patients allows adequate wide local excision and sentinel node sampling

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Background: Breast cancer patients who are medically unfit for general anaesthesia (GA) or who are elderly are often denied any sugery. While lumpectomy under local anaesthesia (LA) has been performed, axillary surgery has been avoided because of difficulty with adequate infiltration and volume required to achieve adequate anaesthesia. Ultrasound guided procedures are becoming routine in our practice. We describe our initial experience of a simple method of ultrasound guided infiltration of local anaesthesia to ensure complete excision of the breast lump and adequate blue node sampling

Material and Method: 1% lignocaine with 1:200,000 adrenaline was used. Generally upto 40 mls were required. We did not have to dilute the anaesthetic. GE logiq 400 CL ultrasound machine with a hand held 11 mHz linear array probe was used. Ultrasound guided infiltration of the breast lump was done using a 22 G spinal needle – this allowed precise infiltration