

determine the time to reach median and quartile survival (25%, 50% and 75%, respectively).

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O-73 SENTINEL NODE BIOPSY MAY BE MORE SENSITIVE FOR DETECTING POSITIVE NODES THAN AXILLARY NODE SAMPLE: RESULTS FROM A RETROSPECTIVE ANALYSIS

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Background: While there have been a number of studies comparing axillary clearance with limited axillary surgery, there is little data available comparing axillary sample (ANS) with sentinel node biopsy (SNB). We report results of a retrospective audit of ANS and SNB procedures performed in a single unit on two sites over a 2 year period.

Results: In total 224 patients underwent limited axillary surgery (ANS $n = 142$ (63%); SNB $n = 82$ (36%)) from January 2008 to January 2010. Sentinel node biopsy was performed using a combination technique with blue dye and radioisotope injections.

The results shown in Table 1 show a significantly greater number of nodes taken with ANS compared with SNB. A significantly higher proportion of patients having SNB had a positive node (22% vs. 9.9%) despite similar baseline tumour characteristics (tumour size, grade and NPI) in SNB and ANS groups, and a greater number of positive nodes following ANC in the ANS group.

These results suggest that SNB is more accurate at detecting positive nodes even in low volume axillary disease. Data from 5 years (approx 500 patients) will be presented.

Table 1

	ANS $n = 142$	SNB $n = 82$	p -Value
Median nodes taken n (range)	4 (1–10)	2 (1–6)	<0.0001
Positive node(s) n of cases (%)	14 (9.9)	18 (22.0)	0.0226
Further positive nodes on ANC n of cases (%)	4 (33.3)	4 (22.2)	0.0547
Total number of positive nodes after ANC mean (range)	2.7 (1–6)	1.3 (1–2)	0.0028

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O-74 HOW OFTEN DOES A POSITIVE SENTINEL LYMPH NODE BIOPSY PROMPT AN ISOLATED DELAYED AXILLARY LYMPH NODE DISSECTION?

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Methods for intra-operative node assessment can avoid delayed axillary lymph node dissection (ALND) in a proportion of sentinel lymph node biopsy (SLNB) patients. Both frozen section and imprint cytology are inconsistent and of variable sensitivity compared to paraffin embedded H&E sections and have not yet been surpassed by molecular assays. Modern approaches to axillary management can contribute to reduction in absolute numbers of isolated completion ALND cases without intra-operative assessment.

A retrospective analysis was undertaken of 443 patients eligible for SLNB with clinically node negative tumours <5 cm. Patients having SLNB before neoadjuvant therapy (27) or immediate breast reconstruction (IBR) (44) were excluded from further analysis together with 15 patients undergoing single stage ALND (level I/II) due to age or co-morbidity. Most of the remaining 357 patients had an axillary ultrasound examination (301/357) with 49 proceeding directly to ALND based on positive nodal core biopsy (40), suspicious nodes with (6) or without (3) a negative biopsy. Amongst 308 patients undergoing SLNB, 73 were node positive (23%) and required completion ALND. Just over half these had an isolated delayed ALND (40), whilst 33 patients had ALND with an additional surgical procedure (re-excision, mastectomy with or without IBR). The recall rate for delayed ALND alone was <10% (40/443).

Intra-operative node assessment may be more difficult to justify for all SLNB patients in the context of contemporary surgical practices which either deselect patients for SLNB or enable any completion ALND to be performed as a component of definitive breast surgery.

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O-75 FINE NEEDLE ASPIRATION CYTOLOGY IS A VALUABLE ADJUNCT TO AXILLARY ULTRASOUND IN THE PREOPERATIVE STAGING OF EARLY BREAST CANCER

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Aims: To determine the predictive values of axillary fine needle aspiration (FNA) cytology and ultrasound (US) and tumour size and the influence of histological grade in the preoperative axillary staging of early breast cancer.

Patients and methods: 314 patients: 119 patients had suspicious US investigated by FNA; 195 patients had normal US not investigated further preoperatively. Review of case records and discrepant cytology.

Results: Positive and negative predictive values (PPV & NPV) for US status and tumour size (T stage are shown in Table 1. Of 195 patients with negative axillary US 37 (19%) had metastatic nodal