

PP-2-13 Breast Conserving Surgery. Is It Too Expensive?

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Less than 10% of breast cancer patients undergo breast conserving surgery (BCS) in our region. The numbers have been falling for the last two years, possibly in order to reduce the treatment costs.

To indicate treatment costs, a retrospective study on patients treated with BCS in our region between 1986–94 was performed. 66 patients (48 pts – pN0) were identified. They had been followed for 2–85 months (median 29 months). 13 pts had relapsed (3 regional and 10 distant) and 5 died of progressive disease, giving a 5-year overall survival of 78%.

The median raised cost in each patient treated with BCS compared to the estimated cost of an alternative mastectomy was calculated to a cost of \$6.310. Employing quality of life (QoL) (BCS QoL = 0.90, mastectomy QoL = 0.80) and survival data (median survival BCS & mastectomy = 10 yrs) in the literature, the cost of one quality adjusted life year (QALY) was estimated to a cost of \$6.310. This may indicate BCS being within reasonable cost and that it should not be displaced by mastectomy on economical reasons.

However, to clarify this question an appropriate control group will be identified, the QoL measured and a cost minimising and cost-utility analysis performed. Data will be presented at the conference.

PP-2-14 Immediate Breast Reconstruction (IBR) in Breast Cancer Patients

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Modified radical mastectomy (MRM) remains one of the most hurting of woman's psychic operation. This is a reason for performing: a) breast conserving operations, b) IBR. The aim of this investigation consists in evaluation of compatibility of IBR with various kinds of antitumoral treatment. We performed the next types of operations included IBR: 1) MRM + IBR by means of transversal recto-abdominal flap (IBR TRAMF) in 51 (T4N0-2M0 – 24, T3N0-2M0 – 15, T2N0-2M0 – 12) patients. 2) MRM + bilateral IBR TRAMF in 1 bilateral metachronous breast cancer patients. 3) MRM + IBR by means of the musculus latissimus dorsi flap in 5 patients. 4) Subcutaneous mastectomy with axillary dissection + IBR TRAMF in 3 patients. 5) Sectoral resection with axillary dissection + IBR TRAMF in 5 patients. 6) Sectoral resection with axillary dissection + bilateral IBR as it made in reduction plastic operation in 6 patients. Breast cancer stage III patients were undergone to preoperative chemotherapy and irradiation and chemotherapy and endocrine therapy as adjuvant treatment. All patients after breast conserving operations were undergone to breast irradiation, including irradiation of the flap in dose 50 Gy. IBR did not made any problem to irradiation, chemotherapy and endocrine therapy.

PP-2-15 Pain and Other Symptoms during the First Year after Surgery for Breast Cancer

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In order to prospectively evaluate pain and other symptoms after surgery for breast cancer 105 women were interviewed and subjected to clinical neurological examination and evaluation of anxiety and depression before surgery and one, six and twelve months after surgery. One year after surgery 80% had treatment related symptoms in the treated breast and virtually all in the ipsilateral arm. The incidence of chronic post treatment pain was higher after breast-conserving surgery, but more severe after mastectomy. 75% had numbness and 30% oedema, 17% had muscle weakness in the ipsilateral arm. Pain influenced daily life at least moderately in 33%, sleep was disturbed by pain in 50% of mastectomy patients. Complete axillary clearance gives considerable arm problems emphasising the need to avoid clearance of node negative axillas.

PP-2-16 Compressive Bandage and Postoperative Complications to Breast Surgery. A Randomised Trial

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Purpose: To assess the effect of short term compressive bandage on the complication rate after mastectomy, mastectomy with axillary dissection and lumpectomy with axillary dissection.

Methods: During a 18 month period 187 patients operated for breast cancer were randomized to: no compressive bandage compressive bandage for 6 hours, or compressive bandage for 24 hours. Block randomisation according to the type of operation took place after wound closure. Records of seroma, haematoma, epidermolysis and necrosis were made. Statistical tests were Chi-square test and Mann Whitney test. Level of significance: 5%.

Results: Forty three patients had mastectomy, 97 mastectomy with axillary dissection and 47 lumpectomy with axillary dissection. Lesser seromas were found among the mastectomy patients, treated with compressive bandage compared to no compression ($p < 0.001$). Fewer hematomas were seen among patients who had lumpectomy with axillary dissection, treated with compressive bandage, compared to no compression ($p < 0.05$). No significant differences between 6 and 24 hours compressive bandage were seen. No adverse effects, i.e. epidermolysis or skin necrosis, of compressive bandage were found.

Conclusion: The use of short term compressive bandage seems to lower the frequency of postoperative seromas and haematomas after certain types of breast surgery.

PP-2-17 Intra Operative HDR Boost in BCT

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Introduction Aim: to study the effects of intra operative HDR boost in BCT. **Methods** From 1990 through 1995, 73 postmenopausal patients (age 45–84) entered in this study. There were two moments of implantation: A) during lumpectomy and irradiation after 3 days when histology showed no contra-indications, and B) in a second session within 2 weeks after the lumpectomy with re-operating the wound to avoid a geographic miss. Staging: pT1 (n = 47) pT2 (n = 25) pT4 (n = 1). Dose (Paris System) 8.9 Gy, this means ETD = 35.3 ($\alpha/\beta = 3$), ETD = 16.8 ($\alpha/\beta = 10$). External beam therapy started within 4 weeks after the implantation, dose 2 Gy 25 fractions 5/wk).

Results: delayed wound healing and/or infections in 5 patients. mild to moderate fibrosis n = 16 (5 with asymmetry). severe fibrosis + asymmetry n = 1. asymmetry without fibrosis n = 9. local recurrence + regional recurrence n = 1. supra clavicular lymfe node metastasis n = 1. death of metastasis n = 3. living with metastasis n = 2. intercurrent death n = 2.

Conclusions. local control is good (though follow up is short). Complications and cosmetic results are acceptable since this technic has also economic advantages we continue this procedure.

PP-2-18 Breast Cancer in Women over 70

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The combination of an aging population, a common cancer and an increase in cancer incidence with advancing age, means that clinicians will encounter increasing numbers of older women with breast carcinoma in future years.

From 1979 to 1989, 260 women aged over 70 were treated at our institute for primary breast cancer. Majority of patients presented with T2 tumor, which was the most common stage at presentation for all aged groups at that time period. Surgery is the treatment of choice: 71% of women had mastectomy, as breast conserving surgery was introduced in the department in the late eighties. The radical surgery was generally well tolerated (mortality less than 1%). An adjuvant treatment was not systematically administered (Tamoxifen or radiotherapy). Women, not fit for general anaesthesia received Tamoxifen alone or in association with a tumor excision under local anaesthesia. Follow-up information is available for 88% of the treated population. The mean follow-up time is 57 months: 44% are free of disease, 2% presented a local recurrence, 7% developed metastasis and 47% deceased (39% from their neoplasia). Survival seems independent of the type of surgery. Local control is optimal after radical mastectomy. Yet, less extensive surgery may be a good alternative for women having an increased operative mortality risk. No adjuvant treatment policy exists for the elderly presenting with breast cancer, even if Tamoxifen and radiotherapy are well tolerated. Breast cancer therapy should be determined by a woman's physiologic age and psychological needs rather than her chronologic age.