PP-2-19 Axillary Lymph Node Dissection for Non-Palpable Breast Cancer — 314 Cases

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A retrospective study concerning 314 axillary lymph node dissections for non-palpable breast cancer is reported. The mammographically detected breast tumors were represented by 43 ductal carcinomas *in situ* (DCIS), 29 microinvasive carcinomas, 242 invasive carcinomas: 208 ductal (IDC), 31 lobular (ILC) and 3 mucinous. The histologic size of the invasive component was $\leq$ 5 mm in 44 cases, 6–10 mm in 103 cases, 11–15 mm in 60 cases. 16–20 mm in 19 cases, $>$ 20 mm in 16 cases. Axillary dissection has been performed immediately in 237 instances (76%) or secondarily in 77 instances (24%) according to the results of intraoperative examination of surgical specimens. Lymph node involvement (N+) was not encountered in DCIS, microinvasive or invasive carcinomas $\leq$ 5 mm. Among the 242 invasive breast carcinomas the N+ was 8.3% (20/242) distributed as follows: 11.5% (11/95) in the category of tumors $>$ 10 mm, 5.8% (9/147) in the category of tumors $\leq$ 10 mm. Owing its virtual morbidity and low likelihood of N+, we question, as others, about the opportunity of axillary dissection for *in situ*, microinvasive and invasive breast cancers 5 mm in maximum diameter and smaller.

PP-2-20 The Timing of Drainage Removal in Breast Surgery

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Several Authors reported different experience regarding the time of axillary drainage removal. Particularly Inwang reports a 49% of axillary seromas in patients whose drainage was removed in 5th postoperative day vs. a 28% in patients with standard drain ramoval. Other Authors used the closure of dead space to reduce seroma incidence. Petrek reports no differences in seroma incidence by using multiple drainages vs only one axillary drainage. Anyway all these and other works demonstrate that axillary seroma after both mastectomy or conservative breast surgery with axillary clearance is still an unresolved problem in terms of postoperative morbidity with an increase of the hospitalization postoperative days.

We introduce results coming from a prospective study regarding the early axillary drainage removal: 59 consecutive breast cancer patients was admitted to the study between January 1994 and May 1995. 28 underwent breast quadrantectomy and 31 a total mastectomy, in all cases was performed a complete (3 levels) axillary clearance. Patients mean age was 57 yrs.

Two suction drainages was placed after surgery and removed after 3 days irrespective of the volume of fluid draining. Mean total fluid drained was in 322.19 ml in quadrantectomy and 301.94 ml in mastectomy. Clinical seroma occurred in 5 cases (8.5%) and treated by fine needle aspiration with a mean resolution in 12.5 days by 2 aspirations plus Deflazacort (30 mg $\times$ 2 for 7 days). In no cases we had septic complicances. Since 3 months we started to take off drains in 2nd p.o. day (14 cases).

We don't find significative differences in daily and total effusion amount between patients who developed seroma vs. patients that do not.

These results in our opinion demonstrate that seroma development is irrespective of the early removal of the drainages, on the contrary it seems that this procedure can reduce the seroma incidence. In our opinion a correct surgical procedure with an accurate conservation of surgical plains (lymphadenectomy performed by exactly following the axillary vein plain) and by reducing the use of electrocautery it is mandatory to achieve this result.

PP-2-21 Breast Reconstruction Following Mastectomy: Our Experience

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During the last decade, breast cancer has been treated more and more often by conservative therapies, with the aim to preserve the shape and the volume of the diseased breast. Nowadays, however, mastectomy is still the treatment of choice in a large number of breast cancer patients. In these cases, the less aggressive operations (radical modified mastectomy according to Patey or Madden) and the developments and refinements of reconstructive techniques allow the surgeon to achieve always better results, with undoubted psychological benefits for the patients.

Breast reconstruction can be performed as immediate or delayed reconstruction using expanders and silicone-gel implants or musculocutaneous flaps. Since severely mutilating operations, like Halsted mastectomy, are today very rare, our current choice is for an immediate "two-stages" breast reconstruction using anatomical expanders and implants. At the end of the radical modified mastectomy procedure, we position, in a submuscular pocket, the anatomical textured-surface expander with an integral filling valve, which is easily found postoperatively with a magnetic finder. After 4–6 months we perform the final stage of the reconstruction, most of the times simply removing the expander and replacing it with the anatomical textured-surface silicone-gel implant. If a better simmetry is needed, a reduction mammaplasty or a mastopexy on the opposite side is performed.

In cases of conservative surgery is today mandatory to achieve a better cosmetic result. This can be obtained in several ways:

In cases of tumors located in lower part of the breast we perform a bilateral operation like the Pitanguy's reductive mammoplasty with an axillary separated cut for the nodes dissection in the site of breast tumor.

In the other cases a breast remodellament is always performed with the replancing of nipple-areola complex.

The results in our experience are very satisfying, the complications rate very low and the patients psychological benefits really encouraging.

PP-2-22 Breast Surgery without Any Antibiotical Prophylaxis

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Breast surgery represents the prototype "clean surgery". The just codified rules of surgical antisepsis and post-operatory management reduce the risk of bacterial contamination. A correct surgical technique does certainly influence the local factors: the choice of the correct plains of dissection by determining a lesser bleeding, reduces post-operatory hematoma and seroma ratio. Moreover, by decreasing post-operatory transfusion necessity and operatory time, two main factors of immunodepression are reduced too. Given such premises, post-operatory sepsis incidence in breast surgery doesn't go over to 2–5%. We can thus understand how several Authors have emphasized how useless antibiotic chemioprophylaxis is in such surgery. Starting 1991 we codified all the surgery cases of breast pathology

– 176 surgery cases for carcinoma both with Mastectomy and/or Quadrantectomy.

– 113 surgery cases for benign breast pathology. In no case did we performed on an antibiotic prophylaxis. We are taking into consideration only the cases starting from 1991, because in these cases we were able to conduct our studies in a computerized very careful way. In major surgery drainages are removed on the III post-operatory day. The results we obtained are encouraging. On an average, patients were discharged on the IV p.o. day, after drainages removal. On 176 patients operated for breast carcinoma only 3 cases contracted a surgical wound infection, followed by abscess. This complication was treated with antibiotic therapy, drainage of the wound and ambulatory medication for about 20 days. There was only 1 case of p.o. infection among the patients who underwent a minor breast surgery. One patient presented a congenital immunodeficiency, with ittiosis and a generalized allergic diatesis.

– Breast surgery 289 cases p.o. infections 4 cases (1.3%).

In our opinion, in order to reduce the incidence of infections in clean surgery such as the breast surgery, it sufficies to observe normal criterias of antisepsis and the measures of surgical technique, such as we have described.

We think it is not necessary, where there is no factors of local and general risks, to prescribe any antibiotic prophylaxis; and the results we obtained seem to give us absolute confirmations on this regard.

PP-2-23 Changing Attitudes among Surgeons towards Breast-Conserving Treatment of Early Breast Cancer

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Introduction: Personal preferences of surgeons are thought to play an important role in the use of breast-conserving therapy (BCT) for patients with early breast cancer.

Methods: In 1987 and 1995, a questionnaire was sent to the surgeons of seven community hospitals in southeastern Netherlands. The response-

rates were 64% (25/39) and 70% (30/41) respectively. The hospitals were covered by the Eindhoven Cancer Registry, which enabled the monitoring of actual treatment policy.

Results: In 1995, 9 surgeons (30%) reported to apply BCT to patients with tumours larger than 3 cm versus one surgeon (4%) in 1987. In 1995, the majority of the surgeons considered multicentric tumour growth, diffuse microcalcifications on the mammogram, and extensive intraductal component as contra-indications for BCT. In 1995, a higher proportion reported rather bad or bad experiences with recurrence after BCT, compared with 1987 (37% versus 13%). Cancer registry data showed an increase in the proportion of patients with operable breast cancer, receiving BCT, from 29% in 1984 to 56% in 1989 ($p < 0.001$). Between 1991 and 1993, the proportion decreased to 46% ($p = 0.07$).

Conclusion: The surgeons in southeastern Netherlands reported a greater use of BCT in larger tumours. The slight decrease in the use of BCT might be attributed to a greater awareness among the surgeons about potential risk factors for local recurrence after BCT.

PP-2-24 Variants of Immediate Breast Reconstruction in Breast Cancer Treatment

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Immediate breast reconstruction IBR followed by different oncological operations is a new perspective direction in surgical breast cancer BC treatment that provides all known kinds of patients rehabilitation and allows to preserves the breast as a femininity symbol. The results of 182 IBR in BC treatment are presented, where Stage I had 11 patients (6%), Singe IIA-76 (41.5%), Stage IIIA-12 (8%), Stage IIB-39 (20.3%), Stage IIIB-44 (24.2%).

Various surgical interventions and reconstructions were performed. 65 patients underwent conserving operations following IBR using transposition the part of latissimus dorsi muscle LDM on the site of the removed breast tissue – 40 (22.4%), 12 (6.6%) using musculocutaneous LDM flap, 6 (3.3%) using TRAM or RAM flaps and 7 (3.8%) with silicone implant or tissue expander. 102 patients underwent subtotal breast removal with nipple-areolar, inframammary fold and about 25% of breast tissue conservation following IBR using LDM flap – 80 patients (44%), TRAM or RAM flafs – 20 (11%) and combination of the implant with different flaps – 2 (1.1%). 15 patients underwent IBR after mastectomy using LDM flap 12 (6.5%), using TRAM flap 2 (1.1%) and 1 (0.6%) with implant.

In case of early BC 24 (12.1%) patients underwent only the surgical intervention, in combination with postoperative radiotherapy RT – 47 (25.8%), with pre- and postoperative RT – 9 (4.9%), and with radiochemotherapy RCT – 9 (4.9%). In case of more extended BC (83 patients – 45.6%) together with RCT, 32 (17.6%) underwent endocrine therapy. 15 patients (8.2%) had postoperative complications after IBR connected with partial skin – 6, and partial flap – 1 necrosis. 6 had the total necrosis of transferred flap, 1 – the partial skin necrosis of abdominal wall and 1 had continued bleeding. In evaluation the results of operations among 168 underwent IBR, 28 patients (16.7%) assessed the cosmetic effect as excellent, 96 – (57.1%) as good, 43 – (25.6%) as satisfied and 1 women as non satisfied. During the period of follow-up that consist from 1 till 6 years 4 patients (2.2%) had local recurrence, 3 – (1.6%) distant methastases and 3 – (1.6%) were died of cancer progression.

Preliminary results of IBR after various surgical intervention in different stages of BC demonstrated it advantage compared with traditional approach of treatment particularly in fast psychological, family, sexual, social and labour rehabilitation.

PP-2-25 Axillary Clearance Without Drainage in Breast Cancer

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Prolonged hospital stay after axillary clearance due to lymphorrhea and subsequent seroma is frequent. In order to reduce these consequences selected patients (pts) underwent after lymphadenectomy an axillary padding by tying together the local muscles. No suction drain was installed. From 10.91 to 12.95, 105 women (mean age: 54 y, extremes: 27–85 y) with breast cancer < 35 mm were operated. Previous (12 pts) or concomitant (93 pts) lumpectomy was associated and followed by breast irradiation. A mean number of 14.9 nodes (extremes: 2–28) was sampled and 38 pts had node involvement. Mean postoperative stay was 2.7 days (extremes 1–14). Nine pts had complications treated conservatively: haematoma (3), infection (2), minor wound dehiscence (4). Seroma occurred in 8 pts needing an unique puncture of 50 and 250 ml in only two of them. Twelve pts complained about axillary pain. Median follow-up at the endpoint (3.96) was 20 months (3–53 months). Six pts have recurred distally and one regionally. Functional outcome was good in 91 pts, 7 pts had mild lymphoedema (+2 cm) and 7 residual pain with a limitation of movement in two of them. Postoperative care is reduced with this technique which should be considered for outpatient treatment.

PP-2-26 Axillary Lymphadenectomy without Drainage

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The technique of axillary padding after surgical conservative treatment of a breast cancer was prospectively evaluated through 152 patients, operated on from december 90 to september 91, and regularly followed since them. This technique avoids any axillary drainage, simplifies the post-operative management, and may decrease early morbidity. However, the question of its physiological mechanism remains unanswered. Our results confirm this method's both feasibility and reproductibility. The absence of drainage simplifies and shortens to 2 or 3 days the post-operative stay in hospital, and this appears as its main benefit. However, early seroma are more frequent, and above all, post-operative pain appears twice as important during the following weeks. Nevertheless, the late functional and plastic results are excellent. Experience has thought us that some patients would or could not expect any profit from this procedure, which we consider only within breast-conserving surgery. As a consequence we do not adopt it on a routine basis, but reserve it for individual situations, the patient being clearly informed of its advantages and temporarily painful inconvenients. The ideal technique resolving the every day question of lymphorrhea remains to be found.

PP-2-27 The Organ-Keeping Operations in the Treatment of the Breast Cancer T1–2 NO MO

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The examinations of the results of the organ-keeping operation in case of the breast cancer T1–2 NO MO stages are held. 1433 patients (T1–2 NO MO stages) with the breast cancer had been treated in the mammological department since 1985 till 1992, for whom were done 1218 radical mastectomies in different modifications and 215 organ-keeping operations — from sectoral resections to radical resection. The advance results of the research confirm the advantages of the organ-keeping treatment so that distant results have no differences from radical mastectomy. The mortality was 15% (patients with metastases during 2–72 months). The rate of the relapse of the tumour was 6.5%.

PP-2-28 Seroma as Complication to Surgery in Breast Cancer. Randomized Study Comparing Drainage and Compressive Dressing of the Wound

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Seroma of clinical significance seems to complicate surgery in breast cancer to a great extent. 17–53% in the literature. In our department seroma was found during two former years in 40% of the cases in spite of two suction drains for 1 day and one drain dependent of volume 3–5 days. In the literature there are only a few papers comparing drainage with other alternatives, but single reports concerning use of compressive dressing.

For two years 200 consecutive patients were randomized to two alternative treatments postoperatively in breast cancer surgery. Patients with breast conservation surgery as well as modified radical mastectomy were included in the study. The axillary dissection procedure was identical in the two types of operation. The patients were after randomization treated as follows: Group 1 got two drains; one drain was removed after one day, whereas the other was kept until volume/24 hours < 50 ml, but not longer than 5 days. Group 2 got on the operation table a firm compressive dressing (Tensoplast) placed in a semicircular manner from sternum to columna. Half of the latitude was overlapped. The following parameters were registered: Days in the hospital. Volume of drainage. Analgesics. Wound infections. Frequency of seromas and need of puncture. Volume of this puncture.

Group 1 had significantly longer stay in hospital, 1.3 days longer. This group had also significantly larger need of analgetics of all sorts. But they had significantly fewer punctures for seroma.