

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 ≤ 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 ≤ 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 ≤ 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 removal. 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 compliances. 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 ir-respective 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 recon-

struction 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 symmetry is needed, a reduction mammoplasty 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 replanting 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 Antibiotic Prophylaxis

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Breast surgery represents the prototype "clean surgery". The just codified rules of surgical antisepsis and post-operative 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-operative hematoma and seroma ratio. Moreover, by decreasing post-operative transfusion necessity and operator time, two main factors of immunodepression are reduced too. Given such premises, post-operative 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-operative 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 suffices 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-