

Thursday, February 26, 1998

16.00–17.45

Session 5 Integrated Therapy: Changing Surgical Procedures for Breast Cancer

S17 The axilla; To clear or not to clear? That is the question!

M. Blichert-Toft. *Rigshospitalet, DK-2100, Copenhagen*

The title suggests that "whether or not to clear the axilla" is still a matter of controversy in the treatment of operable breast cancer. In most guidelines for surgeons in the management of symptomatic breast cancer it is emphasized that histologic node status should be obtained on all invasive tumors either by sampling or clearance of the axilla. No physical examination, no imaging techniques and no tumor markers can replace axillary dissection for staging. Further, axillary node status in potentially curable breast carcinomas is still considered the single best predictor of outcome and the primary determinant for use of systemic therapy. Finally, there is growing approval of the role of loco-regional tumor control leading to increasing attention to removal of involved axillary nodes.

Today, the question to be asked is not "whether or not to clear the axilla". Rather, the question should go: How do we separate node negative patients from those who are node positive without clearing the axilla in all probands. No surgeon would advocate to dissect the axilla in node negative patients provided that nodal status could be procured by using a different technique.

The pros are illustrated by results from the Danish Breast Cancer Cooperative Group, DBCG. In DBCG protocols axillary dissection is compulsory.

National surgical quality standards on axillary dissection will be given together with proposals indicating extension of the surgical procedure. The relationship between tumor diameter and axillary nodal involvement is illustrated and the importance of axillary surgery with the intention to cure is stressed. DBCG results show a frequency of node positivity ranging from 17% in tumors 0–9 mm up to 77% in tumors >50 mm in diameter. The percentage of tumors with 4 and more positive lymph nodes amounts 23% in Npos tumors 0–9 mm. Further, the critical number of lymph nodes to be removed in order to avoiding irradiation of the axilla will be given appropriate attention. Finally, the recognition of excellence in surgical treatment on a national scale with due reference to outcome is considered. It is concluded that meticulous surgery can improve overall survival by quite 10% in absolute terms due to a more accurate staging and better loco-regional disease control.

S18 The axilla; To clear or not to clear? That is the question!

U. Veronesi. *European Institute of Oncology, Milan, Italy*

Axillary dissection is performed for staging purposes. With the increasing rates of very small carcinomas the removal of axillary nodes results in totally healthy nodes in a high proportion of cases. A large number of women therefore suffer from an unnecessary and unpleasant operation which removes a good quantity of normal tissue of the immune system.

A new method (sentinel node biopsy) has been discovered to avoid this blind procedure and to stage the axilla with a minimally invasive procedure. The sentinel node biopsy has a correct predictive power on about 97% of cases.

S19 Pre-surgical chemotherapy

R. Margolese. *Jewish General Hospital, Montreal, Quebec, Canada*

One of the goals for pre-surgical adjuvant chemotherapy for breast cancer patients is the reduction of tumor size to favor conservative breast surgery. There is good biologic rational for this, but the clinical problems the surgeon encounters are quite different from those in traditional breast conserving surgery.

Evidence in favor of pre surgical chemotherapy is derived from experience with the primary treatment of locally advanced breast cancer where initial chemotherapy is extremely effective. Preliminary studies in head and neck tumors and sarcomas also indicate high responsiveness to presurgical therapy. Thus presurgical therapy offers advantages of potentially increased disease free survival and, secondarily, reduction in size of tumor.

The patient population will include many with small or minimally palpable tumors and a substantial number of clinical complete responses will occur. Since clinical response may not assure pathological disappearance of tumor it is still necessary to perform local excision and problems in identifying the exact site of the original tumor can arise.

The National Surgical Breast Project has conducted workshops for its mem-

bership in addressing these issues and a summary of findings will be presented. These involve accurate mapping of the original site, use of preoperative needle localization for persisting microcalcifications, and specific skin markers or tattoos.

One special problem is the issue of control of margins. Tumors may not shrink in a uniform fashion similar to melting ice cubes and there is concern that downsizing the scope of the operation will not maintain the excellent local control rates now obtained in conservative breast surgery. This problem will be documented and techniques for management discussed. Correlations with original tumor size and extent of response may be useful guides to surgical technique.

S20 Integration of plastic surgery in the course of breast cancer surgery to improve final cosmetic result and radicality of tumor excision

J.-Y. Petit. *European Institute of Oncology, Milan, Italy*

In case of mastectomy, the integration of plastic surgery is currently widely admitted. Immediate breast reconstruction with implant or with autologous tissue procedures is frequently proposed to the patient before the mastectomy. However, breast conservative surgery (BCS) is recognized as the treatment of choice in most cancers. Breast conservation is proposed in more than 70% of the primary cancers treated at the IEO of Milan. Such a high percentage of preservation has been made possible thanks to the integration of plastic surgery at the time of the primary surgery. The size of the tumorectomy remains a matter of discussion. Based on the Milan II trial and the R. Holland pathological studies, Veronesi recommended the so called "local radical surgery". A free margin of 2 cm implies a final specimen of at least 5 to 6 cm in diameter for a tumor size of 1 cm. In small or medium size breasts, such resection results in wide glandular defect and poor esthetic results in case of direct closure. Plastic surgery derived from reduction mammoplasty procedures allow much better final cosmetic results which is the goal of the conservative treatment. In 25% of our BCS cases, the plastic surgeon is called upon by the general surgeon to close the glandular defect. However, such glandular remodelling changes the size and the position of the breast. Therefore, in 15% of these cases, a symmetry procedure of the opposite breast has been performed. The reduction of the opposite breast should be taken as a good opportunity to check the glandular tissue. Therefore, a special attention should be given to contralateral mammogram in order to focus the glandular resection on the most dubious areas. Four per cent of occult carcinomas, the half of them were infiltrating, have been found in a series of 350 symmetry procedures performed during a breast reconstruction at the G Roussy Cancer Institute. In conclusion, a close collaboration between oncologists and plastic surgeons is required not only to obtain the best cosmetic results but also to allow a better radicality of the tumor resection and an histological check up of the contralateral breast.

Friday, February 27, 1998

8.30–10.00

Session 6 Integrated Therapy: Primary Adjuvant Systemic Therapy

S21 Preoperative therapy (PROP) for breast cancer

B. Fisher. *National Surgical Adjuvant Breast and Bowel Project (NSABP), Pittsburgh, PA, USA*

NSABP B-18 was conducted to evaluate the worth of PROP for the treatment of stages I and II breast cancer.

Goals: 1) to determine if PROP could more effectively prolong disease-free survival, distant disease-free survival (DDFS), and overall survival (S) than the same chemotherapy given postoperatively (POP); 2) to evaluate response of a primary tumor to PROP and correlate that response with DDFS and S; 3) to determine if PROP permitted more lumpectomies (LUMP) and decreased the incidence of ipsilateral breast tumor recurrence after LUMP; 4) to determine whether PROP "downstaged" axillary nodal status, as indicated by more negative nodes.

Methods: Patients (Pts.; 1523) were stratified according to age, clinical tumor size, and clinical nodal status, then randomly assigned to either LUMP and axillary dissection, or modified radical mastectomy, followed by 4 cycles of Adriamycin/cyclophosphamide (AC) every 21 d, or AC then surgery. All pts ≥50 years received tamoxifen for 5 yrs. LUMP pts. also received postoperative