were compared between those patients who underwent pre-operative MRI and those who did not. Excision margins were considered to be involved if the closest margin measured less than 1 mm.

Results: 96 of 134 patients underwent wide local excision or segmental resection (72%) over a 1 year period. There was no significant difference between the MRI group (n = 29) and no-MRI group (n = 67) in excision margin positivity rates (31% v 29%; p = 0.81) or average specimen weight (91 g ± 71 v 95 g ± 88; mean ± SD). Re-excision for histologically confirmed residual disease was performed in 8 patients. Three patients (10% of MRI group) had a pre-operative MRI and 5 did not (7% of no-MRI group).

Conclusion: Our results suggest that MRI does not currently influence the margin or volume of surgical excision in breast conservation and that surgeons are still primarily guided by their clinical assessment of local extent.

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Preoperative assessment of axillary lymph-node involvement in small breast cancers. Analysis of 893 cases

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Purpose: To predict histological axillary involvement risk (pN+) before surgery.

Methods: In 893 patients with infiltrating carcinoma (T0T1T2 ≤ 3 cm) treated by lumpectomy, axillary dissection and radiotherapy from 1980 to 1991, 6 parameters were analysed.

Results: Global pN+ rate was 25.3%. According to the 6 parameters, we noted:

Clinical size (T)	T0	T1	T2		
	13.8%	19.8%	36.6%		
Histological size (pT) (mm)	0–9.9	10–14.9	15–19.9	20–24.9	25–29.9
	11.1%	17.7%	26.5%	30.1%	36%
Histological subtype	SBR1	SBR2	SBR3	LIC	Other
	18.3%	27.2%	37.8%	22.7%	10%
Age	<40	40–60	>60		
	30.3%	25.8%	22.4%		
Breast size	Small	Large			
	30.1%	24.4%			
Topography	Inner	Central	Outer		
	20.1%	24.4%	28.8%		

After a multivariate analysis, only three factors were significant for pN+ risk: T (p < 0.0001), histological subtype (p = 0.0005) and breast size (p = 0.004). With a combination of these three factors, the pN+ rates vary from 5% to 50%.

Conclusions: Both clinical and pathological characteristics of the primary tumor (specified by core biopsy) can define the pN+ risk, and select the candidates for limited axillary surgery by sentinel node.

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Conservation surgery and specialist treatment

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Introduction: The nature of the survival advantage associated with treatment at centres with larger case-loads and a specialist interest remains uncertain. We report the results of a retrospective study comparing the use of conservation surgery and recurrence rates in specialist and non-specialist units.

Methods: All women aged under 75 diagnosed in a defined geographical area in the West of Scotland were identified for the years 1986–91. From all case-records available (2411, 85% of total), details of operative procedures, pathology, adjuvant therapy and recurrence were obtained.

Results: Specialists compared to non-specialists rarely performed conservation surgery on tumours greater than 3 cm (4% vs 16%, p < 0.001), rarely breached tumour margins (2.5% vs 10%, p < 0.001), rarely performed multiple operations (2% vs 6%, p < 0.001), less frequently left positive margins (5% vs 12%, p < 0.001), re-excised positive margins more frequently (7.5% vs 2.6%, p < 0.001), omitted radiotherapy less frequently (16% vs 32%, p < 0.001) and had recurrence rates significantly lower (10% vs 17%, p < 0.001).

Conclusions: We conclude that specialist treatment using conservation surgery has been more rational, in keeping with guidelines and has resulted in a significantly fewer number of local recurrences.

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Are risk factors for local and distant recurrence following breast-conserving therapy for early breast cancer similar to those following mastectomy?

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Purpose: Risk factors for local recurrence and distant disease after breast-conserving treatment (BCT) and mastectomy were compared by pooling the data of two randomized clinical trials for stage I and II breast cancer patients, trial 10801 of the EORTC and trial 82TM of the Danish Breast Cancer Cooperative Group (DBCG).

Methods: The total number of patients included in the study was 1670: 832 had received modified radical mastectomy and 838 BCT, comprising local excision, axillary dissection, 50 Gy whole breast irradiation and a boost to the tumor bed. Representative slides of the primary tumor were obtained for review for 1508 patient.

Results: There were 73 patients with local recurrence after BCT and 72 after mastectomy, 10-year rates being 10% and 9% respectively. Patients ≤ 35 years (RR = 9.9) and patients with extensive intraductal component (EIC) (RR = 2.7) had a significantly higher risk of local recurrence after BCT, but not after mastectomy. Lobular carcinoma (RR = 2.9) was associated with a higher risk of local recurrence after mastectomy. Patients with tumours of high histologic grade or showing vascular invasion were at an increased risk of local recurrence, irrespective of the type of primary treatment.

Conclusions: From the viewpoint of local control mastectomy may be preferred for patients ≤ 35 years and for those with EIC; and certainly if these factors are combined. The high risk of local recurrence after BCT for patients ≤ 35 years warrants further study to rule out any negative impact of breast-conservation on survival in individual patients. Histologic grade and the presence of vascular invasion appear to be of little importance regarding the choice between BCT and mastectomy.

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The characteristics and management of extremely elderly patients with breast cancer

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Purpose: The surgical management of elderly patients is still controversial. We examined the characteristics and clinical outcome of extremely elderly patients who were 80 years of age and older and suffering from breast cancer.

Methods: We studied the cases of 45 extremely elderly patients who underwent surgery in our hospital between 1966 and 1995. 1) We evaluated the changes in the prevalence of extremely elderly patients on a 10 year basis. 2) Clinical features were evaluated in comparison with patients younger than 80 years of age who underwent surgery during the same period. 3) Extremely elderly patients were divided into two groups: one group consisted of those who underwent axillary dissection (group A, 16 cases), the other consisted of those without axillary dissection (group B, 20 cases). Five-year and 10-year survival rate were analyzed retrospectively.

Results: 1) Extremely elderly patients increased decennially both in number (10 to 32) and proportion (1.2% to 2.0%). 2) Elderly patients tended to include more advanced cases with stage III and IV compared with those younger than 80 years of age (14/45 vs 596/2891, p < 0.08), and also tended to include more ER positive cases (23/30 vs 892/1459, p < 0.08). 3) Five-year survival rate was 66% and 10-year survival rate was 49% in group A. Five-year survival rate was 79% and 10-year survival rate was 40% in group B. Although this study was performed retrospectively, tumor size, breakdown of stages, ER positive rate and use of adjuvant therapy were not different between the two groups.

Conclusion: Axillary dissection is not necessary in extremely elderly patients.