The positive margins were 57 (7.5%): 23 infiltrative and 34 C.D.I.S.. We correlated these patients with several factors: by T 4.8% T1b, 8.6% T1c, and 8.8% T2; by N 6.3% N– and 9.7% N+; by C.D.I.S. 7.3% absent, 8.0% present and 7.7% E.I.C.. 53 (6.9%) local intramammary recurrences developed so far. Their rate among the patients with positive margins was 5.4% instead for negative margins was 6.6%. The distribution of local recurrences by T, N and presence of C.D.I.S. in the breast specimen was as follow: 6.4% T1b, 6.5% T1c, 4.7% T2; 7.7% N–, 3.3% N+; 5.6% C.D.I.S. absent, 8.6% present and 3.9% E.I.C.. These data indicate a direct relationship between the positive margins and the diameter of the primitive tumor. The major percentage of positive margins in the N+ category is probably due to the direct correlation between the linphnode status and the size of the neoplasia: no factors were associated to a higher risk of intramammary recurrences. The fact that the positive margins have had the same rate of local relapses as the negative ones is probably due to the correct policy of the Authors that always reexcised the patients that presented E.I.C. or D.C.I.S. -positive tumor and each type of an extensive margin involvement respectively.

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Microinvasive carcinoma of the breast: Is axillary lymph node dissection indicated?

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Background: The natural history of microinvasive intraductal carcinoma (MIDCIS) is still poorly understood. The definition of microinvasion (MI) is controversial among pathologists. Conflicting reports have been published addressing the clinical management of the patients (pts).

Design: Retrospective study (1980–1996) of 58 MIDCIS treated by lumpectomy or mastectomy, with axillary node dissection. MI was defined as a single focus of invasive carcinoma < = 2 mm or up to 3 foci of invasion each not <1 mm in max diameter. When MI was diagnosed, extensive samples were collected to eliminate larger foci of invasion. Pts were also classified according to other definitions of MI. We used the Van Nuys scoring system for DCIS when it was possible.

Results: The mean age was 51 (28–72), 21 pts were post menopausal, 5 received a substitutive hormonal treatment. Fourty four pts (76%) had mammographically detected microcalcifications, and 14 clinical symptoms (including palpable lesions in 7 cases). DCIS was of comedo (N = 32, 55%), cribriform (N = 10, 17.5%), papillary (N = 9, 15.5%), and solid (N = 8, 12%). Axillary dissection yielded a mean of 11 nodes. Nodal involvement was observed in 3 pts (5 pts) who were treated by mastectomy for extensive lesions (1 N+/13, 15 N+/12, 7 N+/13). High grade comedo DCIS was observed in the 3 cases. Immunohistochemical investigations showed positivity for p53, erbB2, high Ki-67, and weak hormonal receptivity, which was the profile of comedo DCIS. Our results were compared to the literature.

Conclusion: In the absence of a consensus regarding the definition of MI and in absence of clinical and biological predictive criteria of MI, axillary lymph node dissection should still be warranted for MIDCIS.

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Oncologic outcome in patients with breast cancer treated with breast conserving reconstruction

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Purpose: Immediate volume replacement with autogenous tissue has been developed to allow a wider excision without compromising the aesthetic results in breast conserving therapy. Here, we reported the outcome of patients who underwent breast conserving reconstruction.

Method and Results: Wide excision was perfomed in 153 patients underwent wide excision from March 1986 to February 1998. The surgical margins of excised tissue were histologically examined during surgery. If involved, the breast tissue adjacent to the primary site was also excised. Eighteen patients (12%) underwent modified radical mastectomy because of positive surgical margins in the re-excised breast tissue on frozen and/or permanent section, although two patients did not have a second operation because of the limited involvement of the sugrical margins. A mild breast deformity after wide excision was corrected by wide undermining and conization of the residual breast tissue in 66 patients, but a severe breast deformity was corrected immediately by transposing an adipose tissue and latissimus dorsi mini-flap in 69 patients. All of these patients underwent axillary dissection followed by breast irradiation. Consequently, the breast appearance was not different between patients with breast reconstruction and those without. Of 135 patients, only one patient (0.7%) who treated with breast conserving reconstruction developed a breast recurrence, while 5 patients (4%) had distant metastases and 3 of these died. The 10-year survival rate was 97%.

Conclusion: Breast conserving reconstruction can provide adequate local control without compromising the breast appearance.

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Prophylactic mastectomy: Patient selection and development of a surgical technique

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Bilateral prophylactic mastectomy (BPMx) is increasingly the choice of many women at high lifetime risk of breast cancer by virtue of strong family or gene testing but there is no consensus on optimal surgical technique. Women on our unit are only offered BPMx according to a strict protocol after formal risk verification: the uncertainties of BPMx with or without breast reconstruction are discussed fully.

Since 1995, 56 women have been offered BPMx and 48 have proceeded with surgery, 33 by one surgeon, 30 with immediate reconstruction and 3 undergoing conventional simple mastectomy, 2 with autologous free nipple grafts. Initially 4 patients with reconstruction had immediate permanent implants: 2/4 were cosmetically good but 2 were not, and 1 of these subsequently chose implant removal and conventional mastectomy. A novel technique of total glandular mastectomy combined with ptosis-correction mastopexy and submuscular tissue expansion was developed to optimise breast glandular resection and enhance cosmetic outcome. Thin skin flaps are created, and if requested, the nipple/areola skin (NAC) preserved on de-epithelialised bridges. After 6 months' expansion, permanent implants are positioned whilst restructuring the mammary fold.

In 29/30 women NACs were successfully preserved: 1 has had NAC reconstructions. 3/26 had tissue expander device failure. There were no failures from infection. Patients are being carefully followed up to assess long term oncological efficacy and cosmesis.

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Superconservative surgery for early breast cancer: Preliminary results

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Purpose: The superconservative surgical approach without axillary dissection (AD) for early breast cancer treatment is debated, although several prognosticators can be used to choose postoperative therapy. Furthermore, the AD avoidment allows prevention of possible complications, such as arm morbidity. We report a clinical trial to assess the role of AD in selected patients.

Patients and Methods: From 1996 January, 85 patients with breast pT1 were included in the trial, following severe inclusion criteria. All patients underwent a breast wide excision or quadrantectomy without AD, and were randomised for radiotherapy to breast and axilla or breast alone. The adjuvant therapy outcame by ER, grading, and proliferative index (Ki-67). Follow-up included clinical and instrumental examinations, every 4 and 12 months respectively

Results: The preoperative clinical data suggested 82.3% T1 (T1a 2.5%, T1b 8%, T1c 41.8%) and 6.3% T2. 11.4% were non palpable lesions. Clinical node status was N0 in 82.4% and N1a in 17.6%. pT1 was histologically demonstrated in all cases (pT1a 10.7%, pT1b 44%, pT1c 45.3%). The concordance between clinical T and pT and between mammographic T and pT was respectively 42.2% and 48.9%. Radiotherapy was performed on breast and axilla in 52.4% and on breast alone in 47.6%. Follow-up (until 2 years) demonstrated: no local and/or axillary recurrence, and 2 distant relapses. Cosmetic results were good-excellent in 92.9% as functional in 98.2%. 7 patients who underwent axillary radiotherapy developed fibrosis needing physical therapy.

Conclusions: These preliminary data, justify superconservative surgery for patients with early breast cancer (T $\leq$ 1.5 cm) and clinically negative node status. The rationale for a minimally invasive treatment, allowing good cosmetic results, is the high percentage of ER+ cases, which benefit from antihormonal therapy, and the possibility of selecting the cases susceptible of chemotherapy through the prognosticators tested on the primary T. The