

WEDNESDAY 15 SEPTEMBER 1999

## Debate

1246

### High dose surgery – The more the better?

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

From a large study conducted more than 10 years ago we concluded that the metastatic invasion of the axillary nodes in patients with carcinoma of the breast follows a regular, progressive pattern (1). As a rule the nodes of the first level are first involved and then the second and the third level are seeded in successive steps. It appeared that levels of invasion, number of involved nodes, and extent of node metastases are variables that are interrelated to a certain degree: in general, the higher the total number of involved nodes, the more levels are likely to be involved and the higher the frequency of extracapsular invasion. However, the cases with a single lymph node involved showed extracapsular invasion in 40.9%. An important observation was that when the metastatic process was limited to a single axillary node, this metastatic node was always at the first level.

It also appeared very clearly from our data that the three variables (number of nodes levels of involvement and extracapsular invasion) are also related to the size of the primary tumor: the larger the breast carcinoma, the higher the number of nodes involved and in turn the more likely the invasion of the second and third level and the presence of extracapsular metastases.

The cases with a "skipped" distribution of metastatic nodes were rare; cases with involvement of the second and/or the third level without metastases at the first level (8 cases; 1.5%) were very rare.

These data represent an important basis for significant development of conservation surgery which refers to the possibility of avoiding axillary dissection when axillary nodes are negative. Although axillary dissection is an important staging procedure, more and more patients present themselves with small carcinomas and all too often axillary dissection reveals only healthy lymph-nodes. We studied the ability of sentinel node biopsy to predict the status of the axilla in order to obtain information on the safety of foregoing axillary dissection when the sentinel node is negative. We injected <sup>99</sup>Tc labelled human albumin peritumorally in 376 consecutive breast cancer patients (2). Next day, the sentinel node was identified and removed through the acoustic signals emitted by a hand-held gamma probe. Total axillary dissection followed. The pathologic status of the sentinel node was compared with that of the whole axilla. The sentinel node was identified in 371 patients (98.7%) and predicted the condition of the axilla in 359 (96.8%). Twelve false negative cases were found among 203 negative sentinel nodes (6.7%). A randomised trial on the safety and efficacy of sentinel node biopsy is in progress.

1247

### Surgical responsibilities in metastases predominant vs. spread predominant cancers

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In an attempt to standardize diagnosis, staging and treatment flawed concepts regarding the natural history of malignant disease have occurred. Oncologists have forgotten that surgical treatment failure takes two distinctly different directions. Cancer dissemination may progress to lymph nodes, liver and systemic sites (metastases) or it may travel by direct extension to surrounding tissues, peritoneal or pleural surfaces or the resection site (spread). For example, in a majority of breast cancer or melanoma patients surgical treatment failure manifests itself as metastatic disease. Isolated local recurrence of breast cancer may be observed in fewer than 5% of patients because these are metastases predominant cancers. In contrast, in a majority of rectal, stomach, or pancreas cancers surgical treatment failure includes local recurrence and/or peritoneal surface disease. Ultra-radical surgery has no role in the metastases predominant malignancies. The surgeon's goal is to clear the primary tumor and remove sufficient lymphatic tissue as a result of advanced disease. For example, in gastric cancer patients the surgery is required to extend the resection to eliminate as surgical treatment failures all local and regional spread as a pattern of recurrence. Liver metastases and systemic metastases should be the only site for disease progression if surgical responsibilities have been met. This principle of CONTAINMENT is pursued through technological innovations that include centripetal surgery (facilitated by wide exposure with self-retaining retractors), peritonectomy using lasermode electrosurgery and extended lymphadenectomy. The surgeon's responsibility to gain local and regional control goes beyond the primary tumor to include the resection site, the retroperitoneal structures and all of the peritoneal surfaces.